CHAPTER 71

MEDICAID ONLY MANUAL

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SUBCHAPTER 1. INTRODUCTION

10:71-1.1 General introduction

On January 1, 1974, Title XVI of the Social Security Act replaced previous Titles I (Old Age Assistance), X (Aid to the Blind) and XIV (Aid to the Disabled), which were repealed. The Social Security Administration administers Title XVI, Supplemental Security Income (SSI), which provides cash payments to the aged, blind and disabled. Individuals who desire medical care only apply through the county board of social services for the Medicaid Only program under Title XIX.

10:71-1.2 Choice of program by applicant

(a) An aged, blind or disabled person who desires Medicaid and does not wish to receive a money payment may apply for the Medicaid Only program. To qualify for this program, he/she must have financial eligibility as determined by the regulations and procedures set forth in this chapter.

(b) Persons who are neither aged, blind nor disabled qualify for Medicaid benefits when they are determined by the county board of social services to be eligible for AFDC-related Medicaid program. Persons whose eligibility is thus established may choose to receive Medicaid Only benefits without accepting money payments. Regulations governing these programs are set forth in the AFDC- related Medicaid chapter (N.J.A.C. 10:69).

10:71-1.3 Living arrangements

(a) Aged, blind and disabled persons who are living in the community and meet the requirements of the SSI program may receive Medicaid Only.

(b) Aged, blind and disabled persons who are receiving care in an eligible medical institution and, because of income or resources, do not qualify for SSI may be eligible for Medicaid Only.

10:71-1.4 Information on the chapter

This chapter sets forth the policies and procedures necessary for the orderly and equitable administration of the Medicaid Only program as it relates to the aged, blind and disabled. It is a statement of policy and procedures separate from all other assistance programs, and is applicable to "Medicaid Only." The criteria for determination of eligibility are based on SSI policy and procedure which do not necessarily coincide with standards for other public assistance programs and therefore require separate instructions.

10:71-1.5 Administrative organization

The Medicaid Only program is administered by the county boards of social services (CBOSS) of the State of New Jersey through the Division of Medical Assistance and Health Services in the Department of Human Services. The CBOSSs contract with the Division of

Medical Assistance and Health Services for the purpose of providing Medicaid Only benefits to eligible persons.

10:71-1.6 Basic principles of administration

(a) The following principles of administration shall apply to the Medicaid Only program.

1. Any aged, blind or disabled person who believes he/she is eligible shall be assured an opportunity to make application (including reapplication) for Medicaid Only by completing the appropriate application form.

2. The applicants or beneficiaries are the primary source of information. However, it is the responsibility of the agency to make the determination of eligibility and to use secondary sources when necessary, with the applicant's knowledge and consent.

3. No duplication of assistance: No beneficiary of Medicaid Only shall receive, during the same period, any other medical assistance from the State or any political subdivision thereof with respect to any maintenance requirements or other need for which allowance is made in the Medicaid Only program (see N.J.A.C. **10:71-**3.14 regarding inmates of correctional institutions). The food stamp program is not considered a duplication of public assistance.

4. There shall be strict adherence to law and complete conformity with administrative policies. Requirements other than those established by law or regulations shall not be imposed on any person as a condition of receiving medical assistance.

5. The applicants or beneficiaries shall have the right to request appeal on the action or inaction of the agency whenever they believe that they have not been given full consideration under the law. A fair hearing shall be conducted by an impartial official of the Department of Human Services in accordance with prescribed procedure when:

i. An application for Medicaid Only is denied;

ii. An application for Medicaid Only is not acted upon by the county welfare board within 30 days for the aged and 60 for the disabled or blind; or

iii. Medicaid Only is terminated.

6. Information about applicants and beneficiaries and their circumstances shall not be disclosed except as required for the proper and efficient administration of the program and only to those agencies involved in the lawful administration or operation of public welfare functions or services.

7. There shall be no discrimination on grounds of race, color, religion, sex, national origin or marital, parental or birth status by state or local agencies in the administration of any public assistance program.

10:71-1.7 Examination or review of chapter

This chapter is a public document. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each CBOSS office for examination or review during regular office hours on regular work days.

10:71-1.8 County board of social services responsibility; chapter

The director of the CBOSS shall assign copies of this chapter to staff members as appropriate and shall ensure that such persons are thoroughly familiar with its contents, apply the required policy and procedures correctly, and keep up- to-date on all policy

changes.

10:71-1.9 Providing chapter material in adverse action situations

Specific chapter material necessary for an applicant or beneficiary or his or her representative to determine whether a hearing should be requested or to prepare for a hearing shall be provided to such persons without charge.

10:71-1.10 Revisions of the chapter

The Division of Medical Assistance and Health Services shall issue revisions and changes to this chapter as necessary. It is the responsibility of each holder of the chapter to maintain its accuracy by inserting new material and removing obsolete pages promptly.

10:71-1.11 Availability of chapter

(a) A current up-to-date copy of the chapter or any part of it is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

(b) All public and university libraries which have agreed to keep the chapter up-to-date will have a copy available under their regulations.

(c) Each legal services office will be furnished with a copy of this chapter free of charge.

(d) Welfare, social service and other non-profit organizations will be furnished with a copy of the chapter at no cost by an official written request to the Division of Medical Assistance and Health Services.

(e) All supplementary State policy directives will routinely be sent to those who have been supplied with the chapter. A mailing list will be maintained by the Division.

END OF SUBCHAPTER 1

SUBCHAPTER 2. THE APPLICATION PROCESS

10:71-2.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

"Application process" means all activity performed by the Income Maintenance Section relating to a request for medical assistance payments. The application process is primarily geared toward the determination of basic eligibility. However, since intake by its very nature involves a combination of services and income maintenance functions, a service worker shall be available as required during such process.

"Applicant," in Medicaid Only, means the aged, disabled or blind individual or his/her authorized agent who executes the formal written application (PA- 1G).

"Approved" means that the applicant has been determined to be eligible for Medicaid Only.

"CBOSS" means county board of social services.

"Disposition of the application" means the official determination of the CBOSS that one of the following actions is appropriate: approval or rejection as defined in the section.

"MRT" means Medical Review Team.

"New application" means a written request for assistance from an individual or his/her agent who has never previously requested assistance in any county in the State under the Medicaid Only program.

"Pending application" means the general term for application, reapplication, reopened application or transfer application prior to official disposition.

"Reapplication" means a written request for assistance by the individual whose previous application was rejected in any county in the State and who requests reconsideration of his/her current eligibility for Medicaid Only.

"Registration" means the action of the CBOSS in assigning a control number to an application.

"Rejected" is an inclusive term (for statistical purposes) for the following actions:

1. Denied means that the applicant has been determined to be ineligible for assistance for a specific reason.
2. Dismissed means official recognition that eligibility need not be considered further because:

i. The applicant died (however, if there were unpaid medical bills incurred subsequent to

inquiry or application, whichever occurred first, the application process is to be completed); or

ii. The applicant cannot be located; or

iii. The application was registered in error; or

iv. The applicant moved to another county in New Jersey during the application process.

3. Withdrawn means that the applicant decided not to pursue the application further.

"Reopened application" means a written request by a former beneficiary in any county in the State for reconsideration of his or her current eligibility for the program.

"Transfer application" means a written request for assistance by the individual who at the time of registration is still receiving assistance through the CBOSS of another county from which he or she moved.

10:71-2.2 Responsibilities in the application process

(a) The Division of Medical Assistance and Health Services is the administrative unit of the Department of Human Services responsible for coordinating the administration of Medicaid Only with the Supplemental Security Income program. This Division provides for payment of claims for, and evaluation of health services rendered under, Medicaid Only; maintains administrative liaison with other departmental divisions; and provides professional, medical and paramedical staff which is advisory to this Division in all matters of health care relevant to the administration of Medicaid Only. This Division contracts with CBOSSs for reimbursement of costs of administering the Medicaid Only program.

(b) The Division of Medical Assistance and Health Services and the Commissioner of the Department of Human Services shall establish policy and procedures for the application process and supervise the operation of and compliance with the policy and procedures so established.

(c) The CBOSS exercises direct responsibility in the application process to:

1. Inform the applicants about the purpose and eligibility requirements for Medicaid Only, inform them of their rights and responsibilities under its provisions and inform applicants of their right to a fair hearing;

2. Receive applications;

3. Assist the applicants in exploring their eligibility for assistance;

4. Make known to the applicants the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use;

5. Assure the prompt and accurate submission of eligibility data to the Medicaid status files for eligible persons and prompt notification to ineligible persons of the reason(s) for their ineligibility;

6. The CBOSSs shall also provide supportive social services which will enhance cure and rehabilitation of beneficiaries of Medicaid Only.

(d) As a participant in the application process, an applicant shall:

1. Complete, with assistance from the CBOSS if needed, any forms required by the

CBOSS as a part of the application process;
2. Assist the CBOSS in securing evidence that corroborates his/her statements;
3. Report promptly any change affecting his or her circumstances.

10:71-2.3 Policy and procedure on prompt disposition

(a) The maximum period of time normally essential to process an application for the aged is 30 days; for the disabled or blind, 60 days.

(b) "Date of effective disposition" based upon either administrative or board action means:
1. In the case of an approved application, the effective date of the application. (Either the date of application, or the date of form PA-1C, whichever is earlier);
2. In the case of a denied application, the date on which written notification informing the applicant of his or her lack of eligibility and the reason therefor is sent to him or her;
3. In the case of a withdrawn application, the date on which written notification confirming to the client that the agency has taken cognizance of his or her voluntary withdrawal is sent to him or her; or
4. In the case of a dismissed application, the date on which written notification informing the applicant of the dismissal and the reasons therefor is sent to him or her.

(c) It is recognized that there will be exceptional cases where the proper processing of an application cannot be completed within the 30/60 day period. Where substantially reliable evidence of eligibility is still lacking at the end of the designated period, the application may be continued in pending status. In each such case, the CBOSS shall be prepared to demonstrate that the delay resulted from one of the following:
1. Circumstances wholly within the applicant's control; or
2. A determination to afford the applicant, whose proof of eligibility has been inconclusive, a further opportunity to develop additional evidence of eligibility before final action on his or her application; or
3. An administrative or other emergency that could not reasonably have been avoided; or
4. Circumstances wholly outside the control of both the applicant and CBOSS.

(d) When the complete processing of an application is delayed beyond 30 days for the aged or 60 days for the blind or disabled, written notification shall be sent to the applicant on or before the expiration of such period, setting forth the specific reasons for delay.

(e) Each county director of welfare shall arrange operational procedures and establish appropriate operational controls within his or her staff organization to expedite the processing of applications and assure the maximum possible compliance with these standards.

(f) Control records on the exceptional cases shall disclose at any time the identity of all applications which have been in pending status beyond normal limits for processing and the reason therefore. Such record shall be adequate to make possible the preparation of a report of such information at any time it might be requested by the CBOSS or the Division of Medical Assistance and Health Services.

10:71-2.4 Intake policy and procedure

(a) "Intake" is a term applied to the CBOSS's activities in relation to requests for information pertaining to or requests for Medicaid Only.

(b) When a client or a representative of a client inquires, for Medicaid Only, an appointment for an interview with the client shall be arranged promptly. Such inquiries shall be recorded as inquiries unless and until there is an interview which results in a decision to make application for assistance.

(c) When the inquiry is by letter or telephone, an appointment, if requested, shall be arranged promptly. An application for Medicaid Only is not to be taken if applicant plans to or has applied for SSI.

(d) All inquiries and referrals shall be cleared with the State Data Exchange (SDX) and any previous information on file shall be made available to the worker for the initial interview.

10:71-2.5 Application policy and procedure

(a) Application for Medicaid Only may be taken by the CBOSS where the applicant resides or is institutionalized at the time of making application.

(b) A legally appointed guardian shall always be recognized as an authorized agent to initiate an application to establish eligibility for Medicaid Only.

(c) In Medicaid Only, an individual who wishes to apply may be confined at home or at an institution, or may be subject to a critical illness or injury which impedes action on his or her own behalf. Consequently, the CBOSS shall accept any one of the following, in order of priority as listed, as an authorized agent for the purpose of initiating an application:

1. A relative by blood or marriage;
2. A staff member of a public or private welfare agency of which the person is a client, who has been designated by the agency to so act;
3. A physician or attorney of whom the person is respectively a patient or client;
4. A staff member of an institution or facility in which a person is receiving care, who has been designated by the institutional facility to so act.

10:71-2.6 Registration procedures and record of inquiries

(a) Official registration of an application consists of the following steps:

1. Entry in application register under appropriate classification as new, reapplication, reopened application or transfer;
2. Assignment of case control number (registration number) to a new application, or reassignment of previous number to a reapplication or reopened application;
3. Preparation of appropriate form PA-9, registration card.

(b) So far as possible, registration shall be completed on the same day that application for assistance is made. If the application is made outside the CBOSS office, registration shall

be completed within three working days.

(c) An inquiry is any request for information about assistance programs which is not a request for an application. A record is necessary only when the inquiry requires follow-up action.

(d) The Institutional Services Section makes Medicaid Only referrals for adults contemplating discharge from specific state and county institutions. These cases are to be registered within two working days.

10:71-2.7 Reports to the Commission for the Blind and Visually Impaired under specified circumstances

By law, the CBOSS is required to report to the Commission for the Blind and Visually Impaired, every individual coming to its attention who is known to be, or who is believed likely to become, permanently blind. The permanent information shall be registered with the Commission in the prescribed form.

10:71-2.8 Assignment of pending application for completion of eligibility determination

Each CBOSS shall provide a method to assure assignment of pending application to a worker within three working days and establish a follow-up tickler system.

10:71-2.9 Process of establishing eligibility

The process of establishing eligibility involves a review of the application for completeness, consistency, and reasonableness. A personal face to face interview with the applicant or his/her authorized agent is required.

10:71-2.10 Collateral investigation

(a) "Collateral investigation" shall refer to contacts with individuals other than members of applicant's immediate household, made with the knowledge and consent of the applicant(s).

(b) The primary purpose of collateral contacts is to verify, supplement or clarify essential information.

(c) The applicants will usually be able to help select the most likely sources of information about themselves. If they are unwilling to have the necessary inquiries made and are unwilling to secure the required information from such sources themselves, then it shall be explained that the CBOSS will be unable to certify entitlement to Medicaid Only.

10:71-2.11 Case recording

All pertinent information relating to the eligible applicant shall be recorded.

10:71-2.12 Recommendation for agency decision

The eligibility worker is initially responsible for the recommendation for approval or denial. The eligibility worker will complete the work sheet and authorization for medical assistance

PR-1 and a copy will be sent to the Medicaid unit for preparation of the MAP-1. The statement of income available for nursing home payment PR-1 (formerly PA-3L) will be completed in appropriate cases.

10:71-2.13 Supervisory review and approval

(a) In most cases an eligibility worker will complete the investigation and processing of the application.

(b) All records shall be reviewed by a supervisory staff member prior to final disposition.

(c) Any difference of opinion between worker and supervisor shall be resolved by a conference, and, if necessary, the issue shall be referred to a higher administrative level for disposition.

(d) All records of application shall be approved in writing by the supervisor following review, either by signature or initialed transcript signature.

10:71-2.14 Disposition of application

(a) It is the intent of State law and policy that the normal method for disposing of applications recommended for approval shall be by the authority vested in the director of welfare to make decisions on eligibility for Medicaid Only. The director of welfare has the same authority to make case decisions other than approvals.

(b) The director may delegate such authority to any staff member or members as he/she may determine. He/she shall exercise this right of delegation in such a way as to assure the available at all times of some staff member possessing the requisite authority to make decisions and to authorize payment by the Division of Medical Assistance and Health Services.

(c) Applications which may be held for the welfare board are:

1. Those where immediate medical need is not indicated; or
2. Those where the director believes that there is valid cause to question the available evidence on any point of eligibility, or where the case presents a special problem;
3. If so held, the application shall be identified in the narrative portion of the minutes, and in each instance shall include a brief statement of the question or special problem involved and the decision of the board.

10:71-2.15 Notice of agency decision

Designation of personnel responsible for preparation of decision notices shall be at the discretion of the agency.

10:71-2.16 Retroactive eligibility for Medicaid

(a) All applicants for Medicaid Only shall be queried as to whether or not they have outstanding unpaid medical bills incurred within the three month period prior to the month of application for Medicaid Only. Those indicating the existence of such bills are to be supplied

with an "Application for payment of unpaid medical bills," form FD-74, for completion. The intake worker will be responsible for assisting the applicant, where necessary, in the interpretation and completion of the application form (regardless of whether the individual is eventually determined to be eligible for Medicaid). The intake worker will not be responsible for making a financial determination of eligibility for the three-month period in question.

(b) The applicant shall attach all outstanding unpaid medical bills to the FD- 74 form and forward it to the:

Division of Medical Assistance and Health Services
Retroactive Eligibility Unit
PO Box 712 Mail Code 10
Trenton, NJ 08625-0712

(c) For individuals who are incapable of acting on their own behalf, an authorized agent can make application for retroactive Medicaid eligibility when there are outstanding medical bills. Such persons, at the time of application, should be provided with a form FD-74 for completion and submission to the retroactive eligibility unit with the unpaid medical bills attached.

(d) In the case of an individual who is deceased, an authorized agent, as defined above, may make application for retroactive Medicaid eligibility by obtaining an application form FD-74 from either the county welfare board or the Medicaid District Office.

END OF SUBCHAPTER 2

SUBCHAPTER 3. ELIGIBILITY FACTORS

10:71-3.1 General provisions

(a) Eligibility must be established in relation to each legal requirement to provide a valid basis for granting or denying medical assistance.

(b) The applicant's statements regarding his/her eligibility, as set forth in the application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources, either documentary or nondocumentary:

1. Documentary sources of evidence present factual information recorded at some previous date by a disinterested party and filed as part of a record. Examples: certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth.
2. Nondocumentary sources of evidence are factual oral statements which appear to be reliable by individuals, based on the observation and personal knowledge of applicant's circumstances.

10:71-3.2 Citizenship; requirements

(a) The applicant must be a resident of the United States who is either a citizen or an alien who can be classified as an eligible alien in accordance with this subchapter.

1. An individual who cannot be classified as an eligible alien in accordance with this subchapter due to changes mandated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) but who was residing in a Medicaid-certified nursing facility prior to January 29, 1997, will continue to be eligible for medical assistance until the individual is no longer eligible for long-term care services.

10:71-3.3 Citizenship; alien status-documentation requirements

(a) A person born in the United States is, by definition, a United States citizen. The United States is defined as the Continental United States, Alaska, Hawaii, Puerto Rico, Guam, and the Virgin Islands of the United States. Native-born persons of American Samoa and Swain's Island are also regarded as citizens of the United States.

(b) Naturalized citizens are those persons upon whom United States citizenship is conferred after birth. This may be accomplished through individual or collective naturalization or, under certain conditions, citizenship may be derived from a naturalized parent. Thus, a child(ren) of a naturalized parent(s) is automatically considered a naturalized citizen(s). Women who themselves could be lawfully naturalized and, prior to September 22, 1922, were married to citizens, or were married to aliens who became citizens before that date, automatically became citizens. On and after that date, standard immigration and naturalization service conditions have to be met before any person can become a naturalized citizen.

1. A naturalized citizen, unless automatically naturalized as outlined above, should have his/her naturalization certificate as proof of citizenship. If the applicant does not have this

document, the county welfare board should contact the nearest Immigration and Naturalization Service district office to verify that the applicant meets the requirements of a naturalized citizen.

(c) The following aliens, if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to full Medicaid benefits:

1. An alien lawfully admitted for permanent residence;
2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;
3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;
4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;
5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act;
6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980;
7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;
8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;
9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;
10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;
11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and
12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medicaid benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent;

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty;

iii. The alien's child has been battered or subjected to extreme cruelty in the United States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty);

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty;

v. In addition to the conditions described in (c)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for

full Medicaid benefits under this chapter;

vi. The county board of social services shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion, in accordance with 8 U.S.C. § 1641.

(d) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medicaid benefits:

1. An alien lawfully admitted for permanent residence, but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)5 of the Immigration and Nationality Act, but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980, but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (c)12 above, but only after the alien has been present in the United States for five years.

(e) Any alien who is not an eligible alien as specified in (c) and (d) above is ineligible for full Medicaid benefits. Any such alien, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, is entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition includes all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(f) Persons claiming to be citizens and eligible aliens shall provide the county board of social services with documentation of citizenship or alien status.

(g) As a condition of eligibility, all applicants for Medicaid (except for those applying solely for services related to the treatment of an emergency medical condition) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury.

1. The following are acceptable documentation of United States citizenship:

i. A birth certificate;

ii. A religious record of birth recorded in the United States or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was created;

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (INS Form-197, Nationality Certificate (INS Form N-550 or N-570);

vi. A Certificate of Citizenship (INS Form N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, the county board of social services shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county board of social services shall file INS Form G-845 along with the alien registration number with the local INS district office to verify status.

3. The following sets forth acceptable documentation for eligible aliens:

i. Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

ii. Refugee--INS Form I-94 annotated with stamp showing entry as refugee under section

207 of the Immigration and Nationality Act and date of entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8," or "RE-9."

iii. Asylees--INS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from the Asylum Office of the Immigration and Naturalization Service, Forms 688B annotated "274a. 12(a)(5)," or I-766 annotated "A5."

iv. Deportation Withheld--Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year--INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980--INS Form I- 94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant--INS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA."

viii. An American Indian born in Canada--INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes--Membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant--INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7, or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county board of social services should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county board of social services shall ask the alien to present Form I-94. If that form is not available, the county board of social services shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county board of social services shall contact the INS by submitting a Form G- 845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following serve as documentation:

i. For discharge status, an original or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original or notarized copy, of the applicant's current

orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self-declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

10:71-3.4 Residence requirement

An applicant for or beneficiary of Medicaid Only shall be a resident of the State of New Jersey.

10:71-3.5 Resident defined

(a) The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

(b) County residence is not an eligibility requirement and relates only to identification of the CBOSS charged by law with responsibility for the official receipts, registration, and processing of applications. The CBOSS is responsible for institutionalized (including nursing homes, intermediate care facilities, and sheltered boarding homes) applicants and recipients within its county regardless of previous county of residence.

10:71-3.6 Change of county residence

(a) Responsibility for case management shall be transferred from one county to the other when a beneficiary moves to another county.

(b) A temporary visit by the beneficiary shall not be considered to be a change of county residence until that visit has continued for more than a three month period.

1. Whenever it is determined that a beneficiary whose application has not been validated has changed or is planning to change his or her residence from one county to another the CBOSS of origin shall continue medical assistance while completing validation, subject to the time limits set forth in the application process, then transfer the case without delay to the receiving county in accordance with (b)2 below. If the CBOSS of origin is in the process of obtaining medical records, it shall complete the process and forward the medical records to the receiving county.
2. Whenever it is determined that a beneficiary whose application has been validated is planning to change his or her residence from one county to another, it shall be the responsibility of the CBOSS directors of the two counties concerned to effect the transfer without interruption of medical assistance.
3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances surrounding the move.
4. If the move is permanent and the case warrants continued medical assistance, transfer of the case shall be accomplished expeditiously by discontinuance of medical assistance in the county of origin and award of medical assistance in the receiving county, to occur simultaneously in the first month for which the CBOSS directors mutually so arranged.
5. The welfare of the client shall not be adversely affected and his or her right to

uninterrupted medical assistance if in need shall not be prejudiced by disagreement or other administrative difficulty between the counties. Any adverse change in grant resulting from transfer requires timely notice.

i. Since the Medicaid Only client retains the same Medicaid number when he or she moves from one county to another, the county of origin shall not terminate the client from the Medicaid status file, but only from its own register.

(c) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (d) and (e) below.

(d) Applicants: Applicants are those individuals applying for Medicaid in the county of origin who move to the receiving county before the eligibility determination has been completed.

1. County of origin: The county of origin has the responsibility to:

i. Complete the eligibility determination process;

ii. Accrete the individual to the Medicaid Status File (MSF) with the correct effective date of Medicaid eligibility and the new address (in the receiving county); and

iii. Within five working days of the eligibility determination, transfer the case record material to the receiving county in accordance with (e)1i through iv below.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative upon receipt of the case material to advise of the continued receipt of medical assistance; and

ii. Notify immediately in writing the county of origin of the date the case material was received.

(e) Beneficiaries: Beneficiaries include all individuals determined eligible for Medicaid Only.

1. County of origin: The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent PA-1G form (including all verification), Social Security numbers, the beneficiary's new address in the receiving county, and form PR-1 (formerly PA-3L), completed with the individual's circumstances current as of the month of the transfer.

ii. Send with the above case material a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any case material described in (e)1i or iii above.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received. Such communication shall arrange for the client and/or the client's authorized representative to make application within 10 working days of the contact to ensure uninterrupted receipt of medical assistance;

ii. Notify immediately in writing the county of origin of the date the initial case material was received;

iii. Determine eligibility for the individual. Identify and resolve questions of the eligibility determination made by the county of origin and receiving county. Advise the county of origin of any discrepancies in the eligibility determinations between the two counties;

iv. Certify eligibility for medical assistance (provided application to transfer has been made) effective for the next month if the initial case material has been received before the 10th of the month;

v. Certify eligibility for medical assistance (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Medicaid Status File (MSF), if necessary. If the individual is determined eligible for Medicaid Only in the receiving county, there shall be no interruption of Medicaid eligibility and no change to the MSF is necessary. If the individual is determined ineligible for Medicaid Only in the receiving county, Medicaid eligibility shall be terminated, subject to timely and adequate notice, and the individual deleted from the MSF; and

vii. Notify the county of origin of the date eligibility for medical assistance will begin or will be terminated in the receiving county.

(f) Any case for which transfer procedures in (c) through (e) above are not begun within 30 days of the date of original referral, shall be promptly reported by the county of origin to the Division of Medical Assistance and Health Services by letter, setting forth the pertinent available facts. This does not mean that the actual transfer must be completed within 30 days, but rather that the procedures shall be commenced within that time.

10:71-3.7 Eligibility of beneficiaries who leave New Jersey

(a) Whenever a beneficiary wishes to leave New Jersey either to establish a permanent residence or for a temporary visit, he or she shall be advised of the effect of this plan on his or her eligibility for continued medical assistance. Particular care should be taken to advise the beneficiary how to present his or her New Jersey Medicaid validation stub and instruct the provider where to send the bill, should the beneficiary need medical care or hospitalization while out of the State on an approved temporary visit.

(b) It shall be the policy of this State that if a beneficiary leaves New Jersey with intent to establish a permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, or if he or she decides to remain indefinitely in the place outside New Jersey to which he or she had gone for a temporary visit, he or she ceases to be eligible to receive Medicaid.

(c) Visits by a beneficiary for a period of not more than 30 days will be permitted without affecting the beneficiary's eligibility. Absence for longer periods of time must be approved by the Division of Medical Assistance and Health Services.

10:71-3.8 Medicaid eligibility for individuals who enter New Jersey in order to secure medical care

(a) Federal and State statute and regulations expressly bar a duration-of- residence requirement as a condition of eligibility. The New Jersey Medical Assistance and Health Services Act authorizes a grant of medical assistance to a qualified applicant who is a resident of the State which " ... means a person living, other than temporarily, within the State."

(b) When an individual enters this State in order to receive medical care, and applies for Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making this person ineligible for the medical assistance program. It is the responsibility of the county welfare board to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

1. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;
2. Whether the move is part of a carefully conceived social service plan which would serve to meet other requirements of the individual in addition to purely physical needs, for example, a person moves to a nursing home in order to be closer to relatives who are interested in the person's welfare;
3. Whether there is a clear expression of intent on the part of the individual to remain permanently in this State;
4. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he/she came;
5. Whether the State in which the individual previously resided recognizes him/her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

(c) If, after full consideration of these factors, the CBOSS is satisfied that the individual has become a resident of this State, then eligibility for medical assistance is established if the person is otherwise eligible.

10:71-3.9 Age

(a) Age requirements are:

1. The applicant must be 65 years of age or older to be eligible based on age alone.
2. A disabled or blind child must be under 18 years of age, or under 22 years of age and a student regularly attending school and neither married nor the head of the household.
3. A disabled or blind adult must be over 21 years of age and under 65 years of age or between 18 years of age and 22 years of age if not a full-time student.

(b) The applicant must present acceptable proof of age. Among acceptable sources of verification of age are:

1. Birth certificate;
2. Marriage certificate;
3. Church records--baptismal, confirmation membership;
4. Immigration or naturalization papers;
5. Census records;

6. School records;
7. Military service records;
8. Court records;
9. Employment records;
10. Records of public or private welfare agencies;
11. Voting records;
12. Medical records;
13. Affidavit from disinterested persons;
14. Driver's licenses; or
15. Insurance policies.

(c) CBOSSs shall maintain administrative controls to assure:

1. That a disabled or blind beneficiary who becomes 65 years of age continues to have his or her eligibility determined on the basis of disability or blindness if it appears more advantageous to the beneficiary;
2. That a disabled child beneficiary is processed as a disabled adult when reaching 18 years of age, or 22 years of age and a student regularly attending school and neither married nor the head of the household; and
3. That a disabled child beneficiary is processed as a disabled adult when reaching 18 years of age and a student regularly attending school and either married or the head of a household.

10:71-3.10 Disability and blindness factors

For purposes of determining medical eligibility for the Medicaid Only program, the disability and blindness standards shall be the same as for the Supplemental Security Income program under Title XVI of the Social Security Act, as amended by Public Law 92-603.

10:71-3.11 Determination of disability and blindness eligibility; a State function

(a) The determination of disability and blindness eligibility for the Medicaid Only program is a direct responsibility of the medical review team in the Division of Medical Assistance and Health Services. Determination of all other factors of eligibility is the responsibility of the CBOSSs. The medical review team is composed of a medical consultant; and a medical social work consultant; it reviews Medicaid Only applications submitted by the CBOSSs.

(b) In situations where an applicant's disability or blindness appears to meet the definition in section 12 of this subchapter, presumptive eligibility for either of these factors can be granted with the approval of the Medical Review Team (MRT).

(c) If an individual has been determined disabled for Social Security purposes (that is, he or she is currently receiving Disability Insurance Benefits), the CBOSS shall not refer the individual to the Medical Review Team (MRT) for a determination of medical eligibility. The individual shall be considered automatically eligible, in this respect, for Medicaid Only benefits.

1. In the event the Social Security Administration determined within the 12 months prior to

the application for Medicaid Only that the individual was not disabled, the MRT will not make an independent determination of the applicant's disability but will be bound by the determination of the Social Security Administration. If an individual whose Social Security or SSI disability claim was denied within the last 12 months presents new or additional evidence to support that claim, the CBOSS should refer the applicant to the Social Security Administration for a reevaluation of its determination.

2. When the denial by the Social Security Administration occurred more than 12 months prior to the application for Medicaid Only, the (MRT) will make an independent determination of disability.

10:71-3.12 Disability; definitions

(a) An individual is disabled for purposes of this part if he/she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity).

(b) A physical or mental impairment is an impairment which results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinic and laboratory diagnostic techniques. Statements of the applicant including his/her own description of his/her impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

(c) An individual is "blind" for purposes of this part if he/she has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central visual acuity of 20/200 or less.

(d) The presence of a condition diagnosed as addiction to alcohol or drugs will not itself be the basis for a finding that the individual is or is not under a disability.

10:71-3.13 County board of social services responsibility and procedures

(a) The CBOSS shall furnish the Medical Review Team with current, pertinent social and medical information, and obtain any special or additional reports on request.

(b) When it appears that an applicant meets the income and resources requirements for Medicaid Only, arrangements for obtaining medical evidence should be initiated immediately by whichever of the following procedures is applicable to the applicant's situation.

1. When the applicant is currently (within three months) under the care of a private physician, he or she shall be furnished with a copy of Form PA-5 (Examining Physician's Report) to take to the physician for completion.
2. If the applicant is currently receiving treatment in a hospital clinic, public health facility

(that is, tuberculosis clinic, mental health clinic or other outpatient facility) on a regular basis for the medical condition related to his or her application for Medicaid Only, a copy or abstract of the clinic record may be submitted in lieu of the PA-5.

3. If the applicant has been hospitalized within three months for a condition related to the impairment for which he or she is applying for Medicaid Only, an abstract of the hospital record may be submitted for patients in long-term care facilities.

4. In the event none of the above are applicable, the CBOSS should assist the applicant in choosing a physician to complete the PA-5, who is competent to determine the nature and extent or degree of disability.

5. When the applicant states that he or she is blind or that visual impairment is his or her primary disability, the CBOSS shall, prior to submission of the record to the Medical Review Team, obtain a Report of Eye Examination (Form PA-5A) from a qualified medical specialist in diseases of the eye (for example, ophthalmologist), or an optometrist, or from an eye clinic of a general hospital, whichever the individual may select. (The membership directory of the Medical Society of New Jersey is suggested as reference for identification of, in each municipality, physicians specializing in diseases of the eye.) Optometrists are listed in the yellow pages of local telephone directories under the heading "Optometrists--Doctors of Optometry." The Form PA-5A should be transmitted in duplicate to the MRT with any other pertinent medical evidence as outlined above. When appropriate, the Certification of Need for Patient Care in Facility Other Than Public or Private General Hospital (Form PA-4) will be submitted to the Medical Review Team (MRT).

(c) Other evidence, such as education, training, work experience and daily living activities, shall be submitted to the MRT by completion of the PA-6 (Medical-Social Information Report). The PA-6 shall be carefully and completely filled out.

(d) If the applicant refuses to furnish medical or other evidence concerning his or her disability, the application for Medicaid Only shall be referred to the Medical Review Team (MRT) for recommendations.

(e) As soon as medical reports and the Medical Social Information Report (PA- 6) are completed, one copy of each shall be stapled together for transmittal to the MRT. It shall be clearly indicated on the PA-6 that this is a Medicaid Only case. Records transmitted by MRT on a given date shall be listed by registration number and name on an inventory sheet, prepared in duplicate, the cases being grouped by case status. One copy shall be attached to the submittal records, the duplicate retained as CBOSS control.

(f) The CBOSS will prepare a similar inventory and attach cases returned to the CBOSS on a given date. Attached to each will be Form PA-8 (Record of Action) containing the determination of eligibility by the MRT and any necessary instructions.

(g) Upon receipt of records from the MRT, the CBOSS shall examine the PA-8 (Record of Action) for the action of the Medical Review Team and for specific instructions or recommendations, and to note the review date.

(h) Recommendations will be made by the medical consultant to alert the CBOSS to the possibilities of adequate medical care for the client, and to provide specific pertinent questions to be raised with the attending physician. The medical social work consultant will make recommendations to help the CBOSS staff recognize the social problems indicated in the client's situation and the relationship between these problems and his or her physical and mental adjustment.

(i) The following procedures shall be observed in respect to MRT actions:

1. "Approved" cases:

i. CBOSS shall complete, as necessary, determination of eligibility in respect to other factors and, if applicant is eligible, take the necessary action to obtain Medicaid benefits.

ii. When an applicant is not eligible in respect to any other factor, although "approved" for the disability or blindness factor, the application shall be denied.

iii. The CBOSS shall establish and maintain a control file for "approved" cases in order that the date for determination review by the MRT will be observed and considered according to N.J.A.C. 10:71-5.

iv. The Medical Review Team (MRT) shall also maintain a control file in order to ensure appropriate and timely reevaluation by the MRT. The MRT will notify CBOSS one month in advance of cases scheduled for such review. Cases also for reevaluation will be listed on Form PA-655.

2. "Undetermined" cases:

i. If further medical and/or social information is required by the MRT for the initial determination of eligibility, the CBOSS shall obtain the information promptly and resubmit the case. Reports from medical specialists shall be submitted on their own letterheads.

ii. If the applicant fails or refuses to present himself/herself for required examinations or tests, the application shall be referred to the MRT for recommendations.

3. "Disapproved" cases:

i. Any case determined as not medically eligible for "Medicaid Only" by the MRT shall be denied Medicaid Only by the CBOSS.

ii. Appropriate notification shall be given to the applicant as well as any specific recommendations for follow-up care and treatment.

(j) When page 5 of Form PA-5 carries the signature of the medical consultant approving the payment of the examining physician, such payment shall be forwarded to the physician from administrative funds, regardless of whether the action on the record of action is "approved", "disapproved" or "undetermined". (In an "undetermined" case, if the request for additional information relates to an incomplete report from the examining physician, approval for payment will not appear on page 5 of the PA-5.)

(k) Payment for special diagnostic reports shall likewise be forwarded to the medical specialist or clinic from administrative funds regardless of whether the case is "approved", "disapproved", or "undetermined".

(l) Maximum allowances for examining physician (completion of PA-5) are as follows.

1. Examination at office or hospital: $20.00.
2. Examination at patient's home: $30.00.
3. Examination at public institution: No fee.

(m) Diagnostic examination services rules are:

1. This subsection is concerned with medical specialty consultant evaluation services and diagnostic studies (that is, clinical laboratory, diagnostic x- ray and special diagnostic examinations) incident thereto, authorized by a CBOSS upon recommendation of the MRT, when deemed essential as part of the initial determination of medical eligibility.

2. These examinations and procedures are exclusively for diagnostic eligibility, are chargeable as matchable administrative costs and a medical vendor payment should be promptly made upon approval of the consultant's report by the reviewing physician employed by the State agency.

3. The following schedule of fees is exclusive to laboratory, x-ray and other special diagnostic studies which may be required.

i. Diagnostic Consultation and Report (ophthalmologic includes refraction: otological includes audiometric screening) other than psychiatric or neurologic: $45.00.

ii. Diagnostic Consultation requiring complete psychiatric or complete neurological examination or complete neuropsychiatric examination, with detailed report: $50.00.

iii. Electrocardiogram with interpretation and report: $25.00.

(n) Payment of the above allowance is to be approved only when the specialist has received prior authorization to perform the diagnostic evaluation and when the examination is performed by a qualified specialist (that is, eligible for or certified by the appropriate American board; or recognized by hospital, community and peers as a specialist, and practice is limited to the specialty). See current membership directory of the Medical Society of New Jersey.

(o) The fee(s) listed in fees for professional and diagnostic services issued by the Medical-Surgical Plan of New Jersey (Revised 6-1-73) shall be approved when diagnostic x-ray or radioisotope studies, laboratory and/orspecial diagnostic studies are deemed essential by the medical specialist authorized to perform the diagnostic consultant evaluation. Payment based on the allowances listed by the Medical-Surgical Plan, Series 575, shall be limited to medical specialists as defined in the section.

10:71-3.14 Institutional eligibility

(a) Persons who are otherwise eligible for Medicaid Only receive medical coverage while receiving patient care in eligible medical institutions. Such coverage shall be provided through the appropriate payment mechanism of the Division of Medical Assistance and Health Services. The Medicaid Cap income standard is applied only to certain institutions.

(b) Individuals who are inmates of public institutions are not eligible for Medicaid coverage, unless they are receiving care in a Title XIX approved section of such facility.

(c) Individuals incarcerated in a Federal, State or local correctional facility (prison, jail,

detention center, reformatory, etc.) are not eligible for Medicaid coverage. The needs of such individuals (inmates) are met through another agency of the Federal or State government or political subdivision thereof (see N.J.A.C. 10:71-1.6(a)3).

(d) An "institution" is any group living arrangement in which food, shelter and personal care (other than nursing care) are furnished on a continuous basis to four or more persons unrelated to the operator or in which food, shelter and personal care, including nursing care, are furnished on a continuous basis to four or more persons unrelated to the operator; or any establishment or facility licensed or approved by the State of New Jersey.

(e) Application of Medicaid Cap rules are:

1. General or Class A special hospitals: When a person is confined to such a hospital, the Medicaid Cap standard does not apply; eligibility will be determined according to the applicable living arrangement in Table B (see N.J.A.C. 10:71-5.6(c)5).
2. Long term care facilities (eligible private medical institutions): This may include licensed nursing homes, intermediate care facilities, or Class B and C special hospitals. These facilities must be licensed by the Department of Health and Senior Services licensing authority, and approved by the Department of Human Services for provider participation in the Title XIX Medicaid program. When a person is confined to a long term care facility, the Medicaid Cap standard is used.
3. Licensed boarding homes for sheltered care (including nonprofit incorporate homes for the aged): These homes must be licensed by the Department of Health and Senior Services in accordance with N.J.A.C. 8:43. When the person is in a facility of this type, the income standard for licensed boarding home is used.

(f) An "eligible medical institution" outside New Jersey is a public or voluntary medical institution which is licensed, certified or approved by the proper authority of the jurisdiction in which the institution is located, so that the costs of care and services provided therein may be paid. Evidence of such license, certification or approval shall be obtained from the Department of Welfare or similar authority of the jurisdiction in which the institution is located.

1. Use of out-of-state facilities shall be restricted to temporary emergency situations where it is established that there is no eligibility for coverage under a welfare or nonwelfare program in the other state.

10:71-3.15 County board of social services responsibility and procedures; eligibility factors

(a) The CBOSS shall be responsible for determining income and resource eligibility, as outlined in N.J.A.C. 10:71-4, for Medicaid Only when applicant is receiving care in institutions defined above. This does not include residents of the State psychiatric hospitals, the State schools for the mentally retarded, Bergen Pines County Psychiatric Hospital, and Essex County Hospital Center, which are the responsibility of the Institutional Services Section of the Division of Medical Assistance and Health Services.

(b) When eligibility depends upon the disability or blindness factor, the determination of

medical eligibility shall be the responsibility of the medical review team. The CBOSS shall furnish the MRT with current, pertinent social and medical information as outlined in this subchapter.

(c) When eligibility for Medicaid Only has been determined, the CBOSS will complete and process a Medicaid Status File Transaction, Form MAP-1, within ten working days from the date of such determination. The CBOSS will issue and distribute Medicaid validation stubs to Medicaid Only beneficiaries who are not in long term care facilities. The CBOSS will complete the statement of income available for nursing home payment (PR-1) (formerly PA-3L) when appropriate.

(d) A determination of continuing eligibility shall be made in accordance with subchapter 5 of this chapter.

10:71-3.16 Medical assistance units

(a) Medicaid District Office (MDO): The Division of Medical Assistance and Health Services has local medical offices throughout the State, known as Medicaid District Offices (MDOs). The role of these offices is to provide liaison with providers of health services; provide information about Medicaid to beneficiaries and members of the community; provide utilization review in determining the medical need for certain covered services requiring prior authorization; and provide information about Medicaid to, and cooperate with, appropriate agencies in order to ensure maximum utilization of the services available through the Medicaid program.

(b) Any questions with respect to policy, regulations, or procedures of the Medicaid program should be directed to the appropriate MDO as listed at N.J.A.C. 10:49, Appendix, Form #17.

END OF SUBCHAPTER 3

SUBCHAPTER 4. RESOURCES

10:71-4.1 Financial eligibility standards; resources

(a) The resources criteria and eligibility standards of this section apply to all applicants and beneficiaries.

(b) Resources defined: For the purpose of this program a resource shall be defined as any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him/her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his/her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4(b).

(c) Availability of resources: In order to be considered in the determination of eligibility, a resource must be "available." A resource shall be considered available to an individual when:

1. The person has the right, authority, or power to liquidate real or personal property, or his or her share of it:
2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or
3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf in accordance with the following definition and provisions.

i. Definition of "availability of resources in third-party situations": In third-party situations in which applicants/beneficiaries have brought an action or made a claim against a third party who is or may be liable for payment of medical expenses related to the cause of the action or claim, funds are considered available or countable at the moment of receipt by the applicant/beneficiary, his or her legal representative, guardian, relative or any person acting on the applicant's/beneficiary's behalf. Such funds should be considered available or countable at the earliest date of receipt by any of the aforementioned entities.

(1) In determining resource eligibility in accordance with N.J.A.C. 10:71-4.5(a), those funds actually available to the applicant/beneficiary or any person acting on his or her behalf as of the first day of the month subsequent to the month of receipt shall be considered a countable resource, unless otherwise excluded (see N.J.A.C. 10:71-4.4).

(2) If a bona fide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/beneficiary, CBOSSs shall deduct the encumbrances and consider the remaining amount as a countable resource.

(3) If between the date of receipt of such moneys and the first day of the subsequent month the applicant/beneficiary pays outstanding medical expenses and/or other expenses, the CBOSS shall consider only the funds remaining after such payment as a countable resource.

(d) Evaluation of resources: The value of a resource shall be defined as the price that the

resource can reasonably be expected to sell for on the open market in the particular geographic area minus any encumbrances (that is, its equity value).

1. Real property:

i. Sole ownership: When the eligible individual is sole owner and has the right to dispose of the property, the total equity value (see (d)1iv below) shall be counted toward the resource maximum.

ii. Joint ownership or ownership in common: Under joint ownership or ownership in common, the equity value of the property shall be divided by the number of owners and the eligible individual's share counted toward the resource maximum.

iii. Ownership by the entirety: Ownership by the entirety (or tenancy by the entirety) refers to property owned by a husband and wife whereby each member has ownership interest in the whole property which is indivisible. When a married couple (either one or both are eligible) is living together, the total equity value of all nonexempt property shall be counted toward the resource maximum. The same policy shall apply to an eligible couple who have been separated less than six months. If the eligible couple has been separated for six months or more, one half of the value represents a resource to each individual. If one spouse is institutionalized and the other spouse resides in the community, the extent to which either spouse has ownership of the property shall be included pursuant to N.J.A.C. 10:71-4.8.

(1) When an eligible individual and an ineligible spouse own nonexempt property by the entirety and the couple is separated for a full calendar month, the cooperation of both owners is necessary to ascertain resource value. If the ineligible owner expresses willingness to dispose of the property, then its value is divided by the number of owners. If there is no such willingness by the ineligible owner, then no value may be assigned to the property. (See also N.J.A.C. 10:71-4.4(b)6 regarding situations in which a co-owner refuses to liquidate.)

iv. Equity value: The equity value of real property is the tax assessed value of the property multiplied by the reciprocal of the assessment ratio as recorded in the most recently issued State Table of Equalized Valuations, less encumbrance, if any. The Table is available from the State of New Jersey, Department of the Treasury, Trenton, New Jersey 08625.

2. Savings and checking accounts: When a savings or checking account is held by the eligible individual with other parties, all funds in the account are resources to the individual so long as he or she has unrestricted access to the funds (that is, an "or" account) regardless of their source. When the individual's access to the account is restricted (that is, an "and" account), the CBOSS shall consider a pro rata share of the account toward the appropriate resource maximum, unless the client and the other owner demonstrate that actual ownership of the funds is in a different proportion. If it can be demonstrated that the funds are totally inaccessible to the client, such funds shall not be counted toward the resource maximum. Any question concerning access to funds should be verified through the financial institution holding the account.

3. Verification of value: The CBOSS shall verify the equity value of resources through appropriate and credible sources. Additionally, the CBOSS shall evaluate applicant's past circumstances and present living standards in order to ascertain the existence of resources which may not have been reported. If the applicant's resource statements are questionable,

or there is reason to believe the identification of resources is incomplete, the CBOSS shall verify the applicant's resource statements through one or more third parties.

i. Responsibility of applicant: If the third party contact is required in accordance with the provisions above, the applicant shall cooperate fully with the verification process. If necessary, the applicant shall provide written authorization allowing the CBOSS to secure the appropriate information.

(e) Resource eligibility: Resource eligibility is determined as of the first moment of the first day of each month. If an individual or couple is resource ineligible as of the first moment of the first day of the month, subsequent changes within that month in the amount of countable resources will not affect the original determination of ineligibility. If resource eligibility is established as of the first moment of the first day of the month, resource eligibility is established for the entire month regardless of any increase in the amount of countable resources.

1. This policy applies equally to individuals and couples in the month of application. Regardless of the date of application, resource eligibility is determined as of the first moment of the first day of that month.

2. If, prior to the first moment of the first day of the month, the applicant or beneficiary has drawn a check (or equivalent instrument) on a checking or similar account, the amount of such check shall reduce the value of the account. The value of such accounts shall not be reduced by any unpaid obligations for which funds have not already been committed by the drafting of a check.

i. When checks have been drawn on an account, the CBOSS shall review the appropriate account registers or check stubs to ascertain the actual balance as of the first moment of the first day of the month. Full documentation of such circumstances is required.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingles with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

10:71-4.2 Countable resources

(a) Any resource which is not specifically excludable under the provisions of N.J.A.C. 10:71-4.4 shall be considered a countable resource for the purpose of determining Medicaid Only eligibility.

1. No portion of a cash reward offered by the Division of an individual for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of resources for financial eligibility purposes, if the resource is maintained in a separate account, in accordance with N.J.A.C. 10:71 – 4.4(b).

(b) Verification of resources: If verification is required in accordance with the provisions of N.J.A.C. 10:71-4.1(d)3, the CBOSS shall proceed in the following manner:

1. Real property which produces income: If the CBOSS determines that it is necessary to establish whether or not real property is producing income consistent with its current market value (see N.J.A.C. 10:71-4.4(b)5), inquiry shall be made of local real estate brokers, tax assessors, or other persons knowledgeable of the prevailing rate of return on real property in the community.

2. Nonexcludable household goods and/or personal effects: If the CBOSS determines that certain household goods and/or personal effects are not excludable (see N.J.A.C. 10:71-4.4), inquiry shall be made of one or more local merchants who deal in used household goods or personal goods in order to determine the current market value of the resource.

3. The CBOSS shall verify the existence or nonexistence of any cash, savings of checking accounts, time or demand deposits, stocks, bonds, notes receivable, or any other financial instrument or interest. Verification shall be accomplished through contact with financial institutions, such as banks, credit unions, brokerage firms, and savings and loan associations. Minimally, the CBOSS shall contact those financial institutions in close proximity to the residence of the applicant or the applicant's relatives and those institutions which currently provide or previously provided services to the applicant.

(c) Documentation of verification: Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

10:71-4.3 (Reserved)

10:71-4.4 Excludable resources

(a) A resource which is classified as excludable shall not be considered either in the deeming of resources or in the determination of eligibility for participation in the Medicaid Only Program.

(b) The following resources shall be classified as excludable:

1. A house occupied by the individual as his/her place of principal residence, and the land appertaining thereto, shall be excluded:

i. Short temporary absences from home such as trips, visits, and hospitalizations do not affect this exclusion so long as the individual intends, and may reasonably be expected, to return home. An absence of more than six months is assumed to indicate that the home no longer serves as a principal residence. However, if the home is used by a spouse or there is evidence that the absence from the house is temporary, the home may continue to be excluded. With that exception, the CWA shall extend the period only with approval from the Division of Medical Assistance and Health Services.

2. In the determination of resources of an individual (and spouse, if any), an automobile shall be excluded or counted as follows:

i. One automobile is totally excluded regardless of value if, for the individual or a member of the individual's household:

(1) It is necessary for employment; or

(2) It is necessary as a means of transportation for the medical treatment of a specific or regular medical problem; or

(3) It is modified for operation by, or transportation of, a handicapped person.

ii. If no automobile is excluded under (b)2i above, one automobile is excluded as a resource to the extent that its current market value (CMV) does not exceed $4,500. The CMV in excess of $4,500 is counted against the resource limit. Where more than one automobile is involved, the car of highest value may be excluded for use if it is to the advantage of the applicant/beneficiary.

(1) The CMB of an automobile is the value of the vehicle as indicated by the "Average Wholesale Value" in the most recent April or October edition of the Red Book; Official Used Car Valuations.

iii. Other automobiles: Any other automobiles are treated as non-liquid resources and counted to the extent of their equity value.

3. Personal effects and household goods, to the extent that the total equity value of such resources does not exceed $2,000:

i. The amount by which the equity value of such resources exceeds $2,000 shall be countable toward the appropriate resource maximum.

ii. In determining the value of household goods and personal effects of an individual (and spouse), there shall be excluded a wedding ring and an engagement ring.

iii. Prosthetic devices, dialysis machines, hospital beds, wheel chairs, and similar equipment shall not be considered in the evaluation of personal effects, unless such items are used extensively and primarily by other members of the household, as well as by the person whose physical condition requires them.

4. The cash surrender value of all life insurance policies owned and in the control of the individual, if the total face value of such policies does not exceed $1,500 (see also (b)9 below):

i. If the total face value of such policies exceeds $1,500, the total cash surrender value of all policies shall be included as a resource, countable toward the appropriate resource maximum.

5. Nonhome property that is used in a business or nonbusiness self-support activity is excluded from resources when the equity does not exceed $6,000 and the activity produces a net annual return of at least six percent of the excludable equity value. If a net return of six percent on $6,000 equity is shown, but the equity value of the property exceeds $6,000, the excess equity (property value less $6,000) is a countable resource and applied to the resource standards in N.J.A.C. 10:71-4.5. If such property is not excludable because the net annual return is less than 6 percent of the equity value (with exceptions below), the total equity value is an includable resource.

i. A rate of return of less than six percent is considered acceptable when all the following conditions are met:

(1) The property is used in a business income-producing operation; and

(2) Unusual or untoward circumstances cause a temporary reduction in the net rate of return; and

(3) The usual net rate of return is six percent of equity value; and

(4) The individual expects the property to again produce a return of six percent of equity value within 18 months of the end of the taxable year in which the unusual incident which caused the reduction in the rate of return occurred.

ii. Tools and equipment required for employment are assumed to be of a reasonable value and producing a reasonable rate of return and are, therefore, excluded from

resources.

6. The value of resources which are not accessible to an individual through no fault of his or her own.

i. Such resources include, but are not limited to, irrevocable trust funds, property in probate, and real property which cannot be sold because of the refusal of a co-owner to liquidate.

ii. Inaccessible resources shall be reevaluated (regarding their accessibility) at every redetermination.

7. In the case of a blind or otherwise disabled person, resources which have been accumulated in connection with a plan to achieve self-support.

i. To qualify for this exclusion, an individual's plan to achieve self-support shall have been approved by the Division of Vocational Rehabilitation Services or the Commission for the Blind and Visually Impaired, and must be current as of the date of the exemption.

8. The replacement value of excludable resources shall be considered as follows:

i. For insurance proceeds, the amount received from an insurance company for the purpose of replacing or repairing an originally excludable resource, if repair or replacement of such resource occurs within nine months.

(1) The initial nine month period shall be extended for a reasonable period up to an additional nine months when it is determined that the individual had good cause for not replacing or repairing the resource. An individual will be found to have good cause when circumstances beyond his or her control prevented the repair or replacement or the contracting for the repair or replacement.

ii. The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent that they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of the proceeds. If the proceeds are not used in the above manner they shall be counted toward the resource maximum.

9. Burial spaces intended for the use of the individual, his or her spouse, or any other member of his or her immediate family and funds which are set aside for the burial expenses of the individual or spouse, subject to the limits specified below.

i. The following definitions apply in regard to burial spaces or funds:

(1) Burial spaces are conventional grave sites, crypts, mausoleums, urns, or other repositories which are customarily and traditionally used for the remains of deceased persons.

(2) Funds set aside for burial include revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated as set aside for the expenses connected with an individual's burial, cremation or other funeral arrangements.

(3) Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds held in an irrevocable burial contract and irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified for burial expenses.

(4) Immediate family includes an individual's minor and adult children, stepchildren and adopted children, brothers, sisters, parents, adopted parents and spouses of those persons. Dependency and living-in-the-same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they meet this definition.

ii. The exclusion from resources of funds set aside for burial applies only when counting

any portion of the funds toward the resource limit would cause ineligibility due to excess resources.

(1) If the individual or couple would otherwise be ineligible and could be eligible with the application of this exclusion and the individual or couple alleges that funds are set aside for the burial of the eligible individual or his or her spouse, an affidavit indicating such must be obtained.

(A) The amount of funds that may be excluded shall be determined and may not exceed the maximum limit of $1,500 each for the individual and his or her spouse. The maximum limit for each individual is reduced by an amount equal to the amount of funds held in an irrevocable burial trust, an irrevocable burial contract, or other irrevocable arrangement which is available to meet that individual's burial expenses. Each individual's maximum limit is further reduced by the face value of any insurance policy on that individual's life owned by him or her or his or her spouse if the cash surrender value of the policy was excluded in determining the resources of the individual.

(B) In order for burial funds to be excluded, the funds must be separately identifiable (that is, not commingled with other funds or assets which are not set aside for burial). Additionally, the funds must be already designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual attests in writing, that he or she intends to use the funds for his or her burial and agrees to submit within 30 days, documentary evidence that the funds have been designated as set aside for burial.

(C) Any increase in the value of excluded burial funds due to interest on such funds which were left to accumulate or appreciation of such funds after establishment of Medicaid eligibility shall be excluded.

10. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

11. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with the other funds or assets), but held in a separate account. Any increase in the value of the excluded case reward shall also be excluded.

10:71-4.5 Resource eligibility standards

(a) For eligibility in the Medicaid Only Program, total countable resources are subject to the following limits. (See N.J.A.C. 10:71-4.1(b) regarding definition of resources, N.J.A.C. 10:71-4.2 regarding countable resources, and N.J.A.C. 10:71-4.8 regarding resources of a couple when one member is applying for Medicaid for institutional services.)

1. Resource eligibility is determined as of the first moment of the first day of the month. Changes in the amount of countable resources subsequent to the first moment of the first day of the month shall not affect eligibility.

2. In the case of checking accounts, the balance as of the first moment of the first day of the month shall be reduced by the amount of any checks which have been drawn on the account but which have not yet cleared the financial institution.

(b) Resource maximum for a couple: Participation in the program shall be denied or terminated if the total value of a couple's countable resources exceeds $3,000.

1. Definition of a couple: A couple shall be defined as a man and a woman who are legally

married, or who have been determined to be a couple by the Social Security Administration for receipt of RSDI benefits, or who are living together in the same household and presenting themselves to the community in which they live as husband and wife.

(c) Resource maximum for an individual: participation in the program shall be denied or terminated if the total value of an individual's resources exceeds $2,000.

(d) Resource maximum (institutionalized individuals): The resource maximum for an individual in (c) above applies equally to individuals institutionalized in a Title XIX approved facility. Countable resources held in the institution (for example, trust funds, personal needs accounts) together with those held outside the institution, are to be applied toward the resource maximum. If the resource maximum is exceeded, Medicaid eligibility will cease. (See also N.J.A.C. 10:71-4.8 regarding resource eligibility for institutionalized individuals.)

(e) The grandfather clause: An individual who satisfied the following criteria may have his/her resource eligibility determined in accordance with procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous to the individual (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974):

1. The individual was participating in the Medicaid program during December 1973 under one of New Jersey's Federal programs for the aged, blind, or disabled;
2. The individual has, since December 1973, continuously resided in New Jersey;
3. The individual has, since December 31, 1973, continuously been an eligible individual, an eligible spouse, or an essential person participating in the Medicaid program.

i. Essential person status (refers to spouse only): A spouse who received Medicaid coverage in December 1973 because of his/her status as a person "essential" to the existence of an eligible person is also considered eligible for receipt of Medicaid Only benefits under the provision of the grandfather clause. Such spouse must continue to reside with the eligible individual alone in order to retain his/her essential person status.

ii. Once an individual's essential person status is terminated, he/she must again apply for benefits and be determined eligible or ineligible on the basis of criteria used for other newly applying aged, blind, or disabled individuals.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

(g) In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with the other funds or assets), but held in a separate account. Any increase in the value of the excluded case reward shall also be excluded.

10:71-4.6 Deeming of resources

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse or is a child residing in the same household with his or her parent(s) or spouse of parent, the resources of the ineligible spouse or parent(s) is considered in the

determination of eligibility. The amount included as resources to the applicant/beneficiary, whether or not it is actually available, is termed deemed resources.

(b) Applicant/beneficiary living alone: If the applicant/beneficiary lives alone, only his or her countable resources shall be applied to the resource maximum for an individual.

(c) Applicant/beneficiary couple: In the case of an applicant/beneficiary couple, the total amount of the husband's and wife's combined countable resources shall be applied to the resource maximum for a couple. Such individuals will continue to have resources treated in this manner until they have been separated for one calendar month. At such time, the individuals will be considered to be living alone.

1. If one member of an eligible couple enters a Title XIX institution, only the resources of the institutionalized individual will be counted in the determination of his or her eligibility beginning with the date of admission except as provided in N.J.A.C. 10:71-4.8.

(d) Applicant/beneficiary living with ineligible spouse: If the applicant/beneficiary lives with an ineligible spouse, all countable resources of the ineligible spouse are deemed to the applicant/beneficiary. The value of the total countable resources is compared to the resource maximum for a couple. Such individuals will continue to have resources treated in this manner until they have been separated for one full calendar month. At such time, the individuals will be considered to be living alone.

1. Separation due to institutionalization: If one member of the couple enters a Title XIX institution, only the resources of the institutionalized individual will be counted in the determination of his or her eligibility beginning with the date of admission except as provided in N.J.A.C. 10:71- 4.8.

(e) Applicant/beneficiary unmarried and under 18 years of age, living with parents: If the applicant/beneficiary is an unmarried child under the age of 18 years of age who lives with his or her parents (including stepparents), the total value of all countable resources in excess of the appropriate parental resource maximum, cited in (e)2 below, shall be applied toward the resource maximum for an individual (see N.J.A.C. 10:71-4.5). A child will be considered to be not living with his or her parents when he or she has ceased living with them for a period of one calendar month.

1. Child not living with parents due to institutionalization: If a physician has certified that the child's duration of stay in a Title XIX facility (or a combination of such facilities) is expected to be 30 consecutive days or more, such child shall be considered to be not living with his/her parents at the time of such certification. In such circumstances, only the child's own countable resources shall be applied to the resource maximum for an individual.

2. Parental resource maximums (including stepparents):

i. One parent: The total value of countable resources in excess of the source limit for an individual (see N.J.A.C. 10:71-4.5) shall be applied toward the eligible child's resource maximum.

ii. Two parents: The total value of countable resources in excess of the resource limit for a couple (see N.J.A.C. 10:71-4.5) shall be applied toward the eligible child's resource maximum.

3. More than one eligible child: If there is more than one eligible child in the household, the total value of countable resources in excess of the appropriate parental maximum shall be equally divided among such children. In cases of this nature, no part of the value of such resources shall be allocated to ineligible children residing in the household.

(f) Deeming resources of an alien's sponsor: When the sponsor of an alien is subject to deeming provisions (see N.J.A.C. 10:71-5.7) any countable resources of the sponsor in excess of the appropriate resource limit (the resource limit for an individual or the resource limit for a couple if the sponsor resides with his or her spouse) shall be considered to be resources of the alien in addition to whatever resources the alien has.

10:71-4.7 Transfer of resources

(a) The provisions of this section shall apply only to persons who are receiving an institutional level of services, including individuals who are receiving services under a 42 U.S.C. § 1915(c) home and community care waiver under Medicaid, or who are seeking that level of services and who have transferred resources, except as specified in N.J.A.C. 10:71-4.10. An individual shall be ineligible for institutional level services through the Medicaid program if he or she (or his or her spouse) has disposed of resources at less than fair market value at any time during or after the 36 month period immediately before:

1. In the case of an individual who is already eligible for Medicaid benefits, the date the individual becomes an institutionalized individual; or
2. In the case of an individual not already eligible for Medicaid benefits, the date that the individual applies for Medicaid as an institutionalized individual.

(b) The following definitions shall apply in situations regarding the transfer of resources:

1. Fair market value: The fair market value (FMV) is equal to the current market value at the time of resource disposal. The FMV shall be determined in accordance with the evaluation instructions set forth in N.J.A.C. 10:71- 4.1(d).
2. Uncompensated value: The uncompensated value (UV) is the difference between the FMV of a nonexcludable resource (less any encumbrances) and the compensation received by the individual. If the resource was jointly owned before disposal, the UV considered is only the individual's share of that value (see N.J.A.C. 10:71-4.1(d)).
3. Institutionalized individual: An institutionalized individual for the purposes of this section is a person who is receiving care in a Medicaid certified skilled nursing facility, intermediate care facility (level A or B and ICFMR) and licensed special hospital (Class B or C) or Title XIX psychiatric hospital (if under the age of 21 or age 65 and over). Effective October 1, 1990, an institutionalized individual shall include an individual receiving care in a Medicaid certified nursing facility (NF). For the purposes of this section, an institutionalized individual shall include a person seeking benefits under a home or community care waiver program, not including the Home Care Expansion Program. An institutionalized individual shall not include a person who is receiving care in an acute care general hospital.
4. Penalty period: The penalty period is the period of ineligibility for Medicaid coverage for institutional level care established for an individual as a result of the transfer of a resource for less than fair market value. The penalty period begins with the month of the resource transfer and is the lesser of:

i. 30 months; or

ii. The number of months resulting from dividing the uncompensated value of the transferred resource by statewide monthly average lowest semi-private room rate for Medicaid certified nursing facilities as calculated annually. The current average through December 31, 1990 is $3,376.

(c) General procedures: If an individual or his or her spouse described in (a) above (including any person acting with power of attorney or as a guardian for such individual) has sold, given away, or otherwise transferred any resources (including any interest in a resource or future rights to a resource) within the 30 months preceding the date of application or entry into institutional care, the following steps shall be taken and fully documented in the case record:

1. Ascertain and document the FMV of the resource.
2. Document the amount of compensation received by the individual for the transfer.
3. Determine the UV, if any.
4. Add the amount of the UV, if any, to the amount of other countable resources.
5. Notify the applicant, in all cases when any amount of UV is established, of the determination via Form PA-13 before the application is approved or denied.
6. Advise the applicant that he or she may rebut the presumption that a resource was transferred at less than FMV in order to qualify for Medicaid coverage for institutional care (see (i) below).

(d) The provisions of this section apply whether or not the resource would have been considered an excluded resource at the time of its disposal or transfer. However, an individual shall not be ineligible for an institutional level of care because of the transfer of his or her equity interest in a home which serves (or served immediately prior to entry into institutional care) as the individual's principal place of residence and the title to the home was transferred to:

1. The institutionalized individual's spouse;
2. A child of the institutionalized individual who is under the age of 21 or a child of any age who is blind or totally and permanently disabled;

i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability shall be evaluated by the Medical Review Team of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13;

3. A brother or sister of the institutionalized individual who already had an equity interest in the home prior to the transfer and who was residing in the home for a period of at least one year immediately before the individual becomes an institutionalized individual; or
4. A son or daughter of the institutionalized individual (other than described in (d)2 above) who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual and who has provided care to such individual which permitted the individual to reside at home rather than in an institution or facility.

i. The care provided by the individual's son or daughter must have exceeded normal personal support activities (for example, routine transportation and shopping). The

individual's physical or mental condition must have been such as to require special attention and care. The care provided by the son or daughter must have been essential to the health and safety of the individual and consisted of activities such as, but not limited to, supervision of medication, monitoring of nutritional status, and insuring the safety of the individual.

(e) The provisions of this section do not apply to the following resource transfer situations:

1. The resources were transferred to the community spouse (or to another individual for the sole benefit of the community spouse) prior to the entry into institutional care so long as the resources were not subsequently transferred by the community spouse;

i. If funds were transferred to another individual for the sole benefit of the community spouse prior to entry into institutional care, in order that the transfer not be considered to have been for the purposes of qualifying for Medicaid, the funds must have been transferred in the form of a legally binding trust document specifying that the trustee(s) may use the funds solely for the benefit of the community spouse. Should the transferred funds not be so designated, the transfer shall be presumed to be for the purpose of qualifying for Medicaid in accordance with the provisions of this section;

2. The resources were transferred to the community spouse subsequent to the application for Medicaid in accordance with N.J.A.C. 10:71-4.8(a)3; or

3. The resources were transferred from the institutionalized individual or the community spouse to the institutionalized individual's child who is blind or permanently and totally disabled.

i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability will be evaluated by the Disability Review Section of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13.

(f) Resource transferred at fair market value: When the resource was transferred at FMV, the application shall be processed as usual. No special procedure is required.

(g) Resource transferred, resource limit not exceeded: When the UV of a transferred resource, combined with other countable resources does not exceed the applicable resource limit, the application shall be processed as usual.

(h) Resource transferred, resource limit exceeded: When the UV of a transferred resource, combined with other countable resources, exceeds the resource limit, eligibility for institutional level services shall be denied and the procedures below followed:

1. Notify the applicant via Form PA-13 that he or she has transferred a resource at less than FMV, the amount of the UV and the length of the penalty period. Explain that the law states that transfer of a resource at less than FMV is presumed to be for the purpose of establishing Medicaid eligibility for institutional services.

2. Advise the applicant that he or she may rebut the presumption (see (i) below).

3. Prepare a list of such cases for control purposes. The control list shall include the case number, client's name, Social Security number, date of resource disposal, FMV of the resource, amount of UV, and the start and end dates of the period of ineligibility for institutional level services.

(i) Rebuttal of presumption that the resource was transferred to establish eligibility: All applicants or beneficiaries may rebut the presumption that a resource was transferred to establish Medicaid eligibility. If the individual wishes to rebut such presumption, explain that it will be his or her responsibility to present convincing evidence that the resource was transferred exclusively (that is, solely) for some other purpose. The applicant should be assisted in obtaining information when necessary. However, the burden of proof rests with the applicant. Accordingly, when the applicant expresses the desire to rebut the agency's presumption that he or she transferred a nonexcludable resource to establish Medicaid eligibility, the procedures below shall be followed.

1. The applicant's statement concerning the circumstances of the transfer shall be recorded. The statement should include, but need not be limited to, the following:

i. The applicant's stated purpose for transferring the resource;

ii. The applicant's attempt to dispose of the resource at FMV;

iii. The applicant's reasons for accepting less than FMV for the resource;

iv. The applicant's means of, or plans for, supporting himself or herself after the transfer;

v. The applicant's relationship, if any, to the person(s) to whom the resource was transferred.

2. Request the applicant to submit any pertinent documentary evidence (for example, legal documents, realtor agreements, relevant correspondence).

3. Take statements from other individuals if material to the decision.

(j) Factors which may indicate that the transfer was for some other purpose: The presence of one or more of the following factors, while not conclusive, may indicate that resources were transferred exclusively for some purpose other than establishing Medicaid eligibility.

1. The occurrence after transfer of the resource of:

i. Traumatic onset of disability;

ii. Unexpected loss of other resources which would have precluded Medicaid eligibility;

iii. Unexpected loss of income which would have precluded Medicaid eligibility.

2. Resources that would have been below the resource limit during each of the preceding 30 months if the transferred resource has been retained.

3. Court-ordered transfer.

4. Evidence of good faith effort to transfer the resource at FMV.

(k) Agency determination pursuant to client rebuttal:

1. The presumption that a resource was transferred to establish Medicaid eligibility is successfully rebutted only if the applicant demonstrates that the resource was transferred exclusively for some other purpose.

2. If the applicant had some other purpose for transferring the resource, but establishing Medicaid eligibility seems to have been a factor in his or her decision to transfer, the presumption is not successfully rebutted.

3. The determination will not include an evaluation of the merits of the applicant's stated purpose of transferring a resource. The determination will only deal with whether or not the applicant has proven that the transfer was solely for some purpose other than establishing Medicaid eligibility.

4. The final determination regarding the purpose of the transfer shall be made at a supervisory level and documented in the case record.

5. The applicant shall be sent a notice of the decision which shall include his or her right to a fair hearing.

(l) In the case of any resource transfer which occurred between April 1, 1990 and August 20, 1990 and which would otherwise be subject to the provisions of this section, the period of ineligibility for institutional services shall be the lesser of:

1. 24 months; or

2. The number of months resulting from the application of the calculation at N.J.A.C. 10:71-4.7(b)4ii.

10:71-4.8 Institutional eligibility; resources of a couple

(a) In the determination of resource eligibility for an individual requiring long term care, the county board of social services shall establish the combined countable resources of a couple as of the first period of continuous institutionalization beginning on or after September 30, 1989. This determination shall be made upon a request for a resource assessment in accordance with N.J.A.C. 10:71-4.9 or at the time of application for Medicaid benefits. The total countable resources of the couple shall include all resources, to the extent either the institutionalized spouse or the community spouse has an ownership interest. The county board of social services shall establish a share of the resources to be attributed to the community spouse in accordance with this section. (No community spouse's share of resources may be established if the institutionalized individual's current continuous period of institutionalization began at any time before September 30, 1989.)

1. The community spouse's share of the couple's combined countable resources is based on the couple's countable resources as of the first moment of the first day of the month of the current period of institutionalization beginning on or after September 30, 1989 and shall not exceed $84,120, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register, and unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $16,824, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register; or

ii. One half of the couple's combined countable resources.

2. In determining the resource eligibility of the institutionalized spouse, the community spouse's share of the resources is subtracted from couple's total combined resources as of the first moment of the first day of the month of application for Medicaid. If the remaining resources are less than or equal to $2,000, the institutionalized spouse is resource eligible. If the remaining resources exceed $2,000, eligibility may not be established.

i. In the case of an individual whose eligibility for institutional care is determined in accordance with the rules applicable for New Jersey Care (see N.J.A.C. 10:72), resource eligibility will exist when the couple's combined resources, less the community spouse's share of the resources, are equal to or less than $4,000.

3. To the extent that the community spouse's share of the combined resources are not already owned by the community spouse, the ownership of the community spouse's share

of the resources must be transferred to the community spouse within 90 days of a determination of eligibility for institutional Medicaid services. The CBOSS may extend the transfer period if individual circumstances warrant a longer period to affect the transfer. Resources not transferred by the end of the 90-day period (or extension) shall be counted in the determination of eligibility for the institutionalized individual.

i. Eligibility for the institutionalized individual shall be established pending the actual transfer of the resources if he or she attests, in writing, that he or she intends to transfer the community spouse's share of the resources to the community spouse.

4. If a court of competent jurisdiction has ordered that resources be transferred to the community spouse in an amount higher than that authorized in (a)1 above, the higher court-ordered amount shall be recognized as the community spouse's share. Any resource transferred under such a court order shall not be subject to the resource transfer penalty described at N.J.A.C. 10:71-4.7.

5. If, in accordance with N.J.A.C. 10:71-5.7(d), additional resources have been authorized to be set aside for the community spouse in order to provide for a sufficient income maintenance level, such additional resources are not subject to the limitation in this section on the community spouse's share of the couple's combined resources. Any resource transferred to the community spouse under this provision shall not be subject to the resource transfer provision described at N.J.A.C. 10:71-4.7.

6. For purposes of this section, an institutionalized individual does not include any individual who is not likely to remain in a Title XIX facility for a period of 30 consecutive days. If a physician has not certified that the individual's stay in the facility is expected to be a period of 30 or more consecutive days, that individual's Medicaid eligibility will be determined as if he or she continued to reside in the community until he or she has been in a Title XIX facility (or a combination of Title XIX facilities) for a period of 30 consecutive days.

7. For purposes of this section, a continuous period of institutionalization means 30 consecutive days of institutional care in a medical institution, and/or Medicaid funded home and community-based waiver services. Continuity is broken by absences from the institution for 30 consecutive days or the non- receipt of home or community based services for 30 consecutive days.

8. For purposes of determining the community spouse's share of the couple's resources only, countable resources of a couple shall include all resources not subject to exclusion under N.J.A.C. 10:71-4.4, except that one automobile shall be excluded without regard to the dollar limits set forth at N.J.A.C. 10:71-4.4(b)2 and personal effects and household goods shall be excluded without regard to the dollar limits set forth at N.J.A.C. 10:71-4.4(b)3.

9. In determining retroactive eligibility (the three-month period immediately preceding the month of application) based on the first Medicaid application in a continuous period of institutionalization, the community spouse's share of the resources shall be deducted from the couple's combined total resources. If the institutionalized individual subsequently files another Medicaid application for the same continuous period of institutionalization, retroactive eligibility will be based on all resources actually owned by the institutionalized individual.

10:71-4.9 Resource assessment

(a) At the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989), the institutionalized spouse or the community spouse (or a representative of either spouse) may request an assessment of the couple's total countable resources. The purpose of the assessment is to establish the community spouse's share of the couple's total countable resources (see N.J.A.C. 10:71-4.8(a)).

(b) The county board of social services shall, upon a request for a resource assessment, advise the requesting parties of the documentation and verification necessary to make the assessment. When the necessary documentation and verification is not submitted to the county board of social services in a timely manner, the requesting parties shall be advised that the resource assessment cannot be completed. Upon receipt of all relevant documentation of resources from the couple the county board of social services shall establish the total countable resources of the couple. The county board of social services shall notify both members of the couple of the total value assigned to their combined countable resources and the community spouse's share of those resources. A copy of the notice shall be retained at the county board of social services.

1. The county shall complete the resource assessment and notify the requesting parties of its results within 45 calendar days of the request unless third party verification has not been received by the county board of social services or the requesting parties request a delay.

(c) At the time of providing the couple with a copy of the resource assessment, the county board of social services shall advise the couple that there is no immediate right to a fair hearing on the county's resource assessment, but that there will be an opportunity to appeal the findings of the assessment when and if the institutionalized spouse applies for Medicaid.

10:71-4.10 Transfer of assets

(a) The provisions of this section shall apply, effective June 18, 2001, only to persons who are receiving an institutional level of services, including individuals who are receiving services under a 42 U.S.C. § 1915(c) home and community care waiver under Medicaid, or who are seeking that level of service, and who have transferred assets on or after August 11, 1993. An individual shall be ineligible for institutional level services through the Medicaid program if he or she (or his or her spouse) has disposed of assets at less than fair market value at any time during or after the 36 month period, or the 60 month period in the case of a transfer to a trust, immediately before:

1. In the case of an individual who is already eligible for Medicaid benefits, the date the individual becomes an institutionalized individual; or
2. In the case of an individual not already eligible for Medicaid benefits, the date the individual applies for Medicaid as an institutionalized individual.

(b) The following definitions shall apply to the transfer of assets:

1. Individual means:
   i. The individual him or herself who is applying for benefits;
   ii. The individual's spouse;
   iii. A person, including a court or administrative body, with legal authority to act in place of

or on behalf of the individual or the individual's spouse;

iv. Any person including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

2. An institutionalized individual, for the purposes of this chapter, is a person who is receiving care in a Medicaid certified nursing facility, intermediate care facility for the mentally retarded (ICFMR), or a licensed special hospital (Class C) or Title XIX psychiatric hospital (if under the age of 21 or age 65 and over). For purposes of this chapter, an institutionalized individual shall also include a person seeking benefits under a home or community care waiver program. An institutionalized individual shall not include a person who is receiving care in an acute care general hospital.

3. Assets shall include all income and resources of the individual and of the individual's spouse. Assets shall also include income and resources which the individual or the individual's spouse is entitled to but does not receive because of action or inaction by the individual or the individual's spouse; or by any person, including a court or administrative body with the legal authority to act in place of or on behalf of the individual or the individual's spouse; or any person, including a court or administrative body, acting at the direction of or upon the request of the individual or the individual's spouse. Examples of actions that would cause income or resources not to be received shall include, but shall not be limited to:

i. Irrevocably waiving pension income;

ii. Waiving the right to receive an inheritance, including spousal elective share pursuant to N.J.S.A. 3B:8-10;

iii. Not accepting or accessing injury settlements;

iv. Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and

v. Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

4. Resources, for the purpose of asset transfer, shall include all resources, both included and excluded, in accordance with the provisions of this chapter. For example, the transfer of a home, even if it is serving as the individual's principal place of residence, shall be subject to the transfer of assets provisions.

5. Income, for the purposes of this section, shall have the same definition as found in N.J.A.C. 10:71-5. In determining whether a transfer of assets involves countable income, the income disregards in N.J.A.C. 10:71-5 shall be applied.

6. Fair-market value shall be an estimate of the value of an asset, based on generally available market information, if sold at the prevailing price at the time it was actually transferred. Value shall be based on the criteria for evaluating assets as found in N.J.A.C. 10:71-4.1(d).

i. In determining whether or not an asset was transferred for fair-market value, only tangible compensation, with intrinsic value shall be considered. For example, a transfer for "love and affection" shall not be considered a transfer for fair market value.

ii. In regard to transfers intended to compensate a friend or relative for care or services provided in the past, care and services provided for free at the time they were delivered shall be presumed to have been intended to be delivered without compensation. In regard to transfers allegedly intended to compensate a friend or a relative for care or services that were provided in the past, care and services provided for free at the time they were

delivered shall be presumed to have been intended to be delivered without compensation. Thus, a transfer of assets to a friend or relative for the alleged purpose of compensating for care or services provided free in the past shall be presumed to have been transferred for no compensation. This presumption may be rebutted by the presentation of credible documentary evidence preexisting the delivery of the care or services indicating the type and terms of compensation. Further, the amount of compensation or the fair market value of the transferred asset shall not be greater than the prevailing rates for similar care or services in the community. That portion of compensation in excess of the prevailing rate shall be considered to be uncompensated value.

iii. Under a life estate, an individual who owns property transfers the ownership of that property to another individual, while retaining for the rest of his or her life, or the life of another person, certain rights to that property. A life estate entitles the owner of the life estate to possess, use, and obtain profits from the property as long as he or she lives, although actual ownership of the property has passed to another individual. In a transaction involving a life estate, a transfer of assets is involved. In determining whether a penalty shall be assessed in the case of a transfer involving a life estate, the value of the asset transferred and the value of the life estate shall be computed. The value of the asset transferred is computed by determining the fair market value. The value of the life estate is calculated in accordance with the life estate table published by the Health Care Financing Administration (HCFA) at 49 FR Vol. 49 No. 93, 5-11-84 and 26 C.F.R. 20.2031-7. The value of the life estate is determined by multiplying the current market value of the property by the life estate factor that corresponds to the grantor's age. The value of the life estate is then subtracted from the value of the asset transferred to determine the portion of the asset that was transferred for less than fair market value. If only the value of the transferred portion is needed, the current market value of the asset is multiplied by the remainder factor. The transfer in which a life estate is retained shall be considered a transfer for less than fair market value whenever the value of the asset transferred is greater than the value of the rights conferred by the life estate.

7. Uncompensated value (UV) shall be the difference between the fair market value at the time of the transfer (less any outstanding loans, mortgages or other encumbrances on the asset) and the amount of consideration received for the asset. If the asset was jointly owned before disposal, the UV considered shall be only the individual's share of that value (see N.J.A.C. 10:71- 4.1(d)). If the individual is seeking institutional services or applying for an institutional level of services and has a spouse residing in the community, the UV considered shall be either spouse's share of that value (see N.J.A.C. 10:71-4.8).

8. In order for a transfer of assets to be considered to be for the sole benefit of a spouse, disabled child, or disabled individual under the age of 65, for the purposes of this subchapter, the transfer shall have been arranged in such a way that no individual except the spouse, disabled child, or disabled individual under age 65 can, in any way, benefit from the assets transferred either at the time of the transfer, or at any time in the future. For the purpose of this subchapter, the person administering the funds shall only be compensated for the reasonable costs that can be directly attributable to the administration of the funds and for compensation for that administration. In no event shall such compensation exceed the amounts allowed by law for the administration of trusts. The transfer of asset penalty exemption for transfers made for the sole benefit of the spouse, disabled child or disabled

individual under the age of 65 does not impact the treatment of trust pursuant to N.J.A.C. 10:71-4.11.

i. If the transfer instrument provides that there are beneficiaries other than a blind or disabled child, or a disabled individual under the age of 65, the sole benefit requirement shall not have been met if the instrument fails to provide that the State shall be the first remaining beneficiary of residual funds prior to disbursement to any other beneficiary.

9. The look-back period shall be either 36 or 60 months, in accordance with the following:

i. In the case of an individual who is already eligible for Medicaid benefits, the 36-month period prior to the date the individual becomes institutionalized.

ii. In the case of an individual not already eligible for Medicaid benefits, the 36-month period prior to the date the individual applied for Medicaid as an institutionalized individual.

iii. When a portion of a trust is treated as a transfer, the look-back period shall be extended to 60 months from the date the individual applied for Medicaid as an institutionalized individual, or for a non- institutionalized individual, the date the individual applied for Medicaid, or, if the date the transfer was made is later, then the date the transfer was made (see N.J.A.C. 10:71-4.11(e)1iii).

iv. Penalties of ineligibility shall be assessed for transfers which take place during or after the look-back period. Periods of ineligibility cannot be imposed for resource transfers which take place prior to the look-back period.

(c) If an individual or his or her spouse described in (a) above (including any person acting with power of attorney or as a guardian for such individual) has sold, given away, or otherwise transferred any assets (including any interest in an asset or future rights to an asset) within the look-back period, the following steps shall be taken and shall be fully documented in the case record:

1. The fair market value (FMV) of the asset shall be ascertained;

2. The amount of compensation received by the individual for the transfer shall be determined. The uncompensated value (UV), if any, shall be determined by subtracting the FMV from the amount of compensation received;

3. The amount of the UV, if any, shall be added to the amount of the other countable resources;

4. The period of ineligibility for institutional level services that would result from the asset transfer shall be determined (see N.J.A.C. 10:71- 4.10(l));

5. In all cases where the amount of uncompensated value would result in a period of ineligibility, the applicant shall be notified of the determination via Form PA-13. The Form PA-13 shall advise the applicant that he or she may rebut the presumption that an asset was transferred at less than fair market value in order to qualify for Medicaid coverage for institutional level care (see (i) below).

(d) The provisions of this section shall apply whether or not the asset would have been considered excluded or exempt at the time of its disposal or transfer. However, an individual shall not be ineligible for an institutional level of care because of the transfer of his or her equity interest in a home which serves (or served immediately prior to entry into institutional care) as the individual's principal place of residence and the title to the home was transferred to:

1. The legally married spouse of the individual;
2. A child of the institutionalized individual who is under the age of 21 or a child of any age who is blind or totally and permanently disabled. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability shall be evaluated by the Disability Review Team of the Division of Medical Assistance and Health Services, in accordance with N.J.A.C. 10:71-3.13;
3. A brother or sister of the institutionalized individual who already had an equity interest in the home prior to the transfer and who was residing in the home for a period of at least one year immediately before the individual becomes an institutionalized individual; or
4. A son or daughter of the institutionalized individual (other than described in (d)2 above) who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual and who has provided care to such individual which permitted the individual to reside at home rather than in an institution or facility.

The care provided by the individual's son or daughter for the purposes of this subchapter shall have exceeded normal personal support activities (for example, routine transportation and shopping). The individual's physical or mental condition shall have been such as to require special attention and care. The care provided by the son or daughter shall have been essential to the health and safety of the individual and shall have consisted of activities such as, but not limited to, supervision of medication, monitoring of nutritional status, and insuring the safety of the individual.

(e) The application of a transfer penalty as set forth in this section shall not apply when:
1. The assets were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined by the Social Security Administration;
2. The assets were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;
3. The assets were transferred from the individual's spouse to another for the sole benefit of the individual's spouse (see N.J.A.C. 10:71-4.10(b) 7);
4. The assets were transferred to the community spouse subsequent to the application for Medicaid in accordance with N.J.A.C. 10:71-4.8(a)3; or
5. The assets were transferred from the individual or individual's spouse to the individual's child who is blind or permanently and totally disabled.
i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability will be evaluated by the Disability Review Unit of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13.

(f) In determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual as defined in N.J.A.C. 10:71-4.10(b) 8, the transfer shall be accomplished via a written instrument of transfer, such as a trust document, which legally binds the parties to a specific course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. Moreover, the written instrument shall state that the State of New Jersey shall be the first remaining beneficiary. A transfer without such a document shall not be considered to have been made

for the sole benefit of the spouse, child or disabled individual.

(g) When the asset was transferred at fair market value, the application shall be processed as usual. No special procedure shall be required.

(h) When the uncompensated value of transferred assets would result in no period of ineligibility for long-term care level services, the application shall be processed as usual.

(i) When the uncompensated value of transferred assets results in a period of ineligibility for long-term care level services, eligibility for long-term care services shall be denied and the procedures below shall be followed:

1. The applicant shall be notified via Form PA-13 that there has been a transfer of assets for less than fair market value, the amount of the uncompensated value and the length of the penalty period. The Form PA-13 shall state that the law presumes that a transfer of assets at less than fair market value is for the purpose of establishing Medicaid eligibility for long-term level care services.
2. The applicant shall be advised that he or she may rebut the presumption that the transfer of assets was for the purpose of establishing Medicaid eligibility (see (j) below).

(j) Any applicant or beneficiary may rebut the presumption that assets were transferred to establish Medicaid eligibility by presenting convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose. The applicant shall be assisted in obtaining information when necessary. However, the burden of proof shall rest with the applicant. When the applicant expresses the desire to rebut the presumption that he or she transferred assets to establish Medicaid eligibility, the procedures below shall be followed.

1. The applicant's statement concerning the circumstances of the transfer shall be included in the case record. The statement shall include, but need not be limited to, the following:
   i. The applicant's stated purpose for transferring the asset;
   ii. The applicant's attempt to dispose of the asset at fair market value;
   iii. The applicant's reasons for accepting less than the fair market value for the asset;
   iv. The applicant's means of and plans for, supporting himself or herself after the transfer; and
   v. The applicant's relationship, if any, to the person(s) to whom the asset was transferred.
2. The applicant shall be asked to submit any pertinent evidence (for example, legal documents, realtor agreements, and relevant correspondence) with regard to the transfer.
3. Statements shall be taken from other individuals, if such statements are material to the decision. The statement shall indicate if such individual has or had a relationship with the applicant and the extent of the relationship (that is, related by blood or marriage, friendship).

(k) The presence of one or more of the following factors, while not conclusive, may indicate that the assets were transferred exclusively for some purpose other than establishing Medicaid eligibility for long term care services:

1. The occurrence after transfer of the asset of:
   i. Traumatic onset of disability;

ii. Unexpected loss of other assets which would have precluded Medicaid eligibility; or
iii. Unexpected loss of income which would have precluded Medicaid eligibility;
2. Court-ordered transfer (when the court is not acting on behalf of, or at the direction of, the individual or the individual's spouse); or
3. Evidence of good faith effort to transfer the asset at fair market value.

(l) Agency determination pursuant to client rebuttal shall be as follows:
1. The presumption that assets were transferred to establish Medicaid eligibility shall be considered successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose.
2. If the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted.
3. The agency's determination shall not include an evaluation of the merits of the applicant's stated purpose of transferring assets. The determination shall only deal with whether or not the applicant has proven that the transfer was solely for some purpose other than establishing Medicaid eligibility.
4. The final determination regarding the purpose of the transfer shall be made at a supervisory level at the county board of social services and shall be documented in the case record.
5. The applicant shall be sent a notice of the decision, which shall include information on his or her right to a fair hearing in accordance with N.J.A.C. 10:49-10.

(m) For the purposes of this subchapter, the penalty period shall be the period of time during which payment for long-term care level services is denied. An institutionalized individual who is ineligible for payment of long- term care services as a result of an asset transfer shall be precluded from eligibility, but shall be entitled to ancillary services if otherwise eligible.
1. In accordance with 42 U.S.C. § 1396p(c)(1)(E), the penalty period for asset transfer shall be the number of months equal to the total, cumulative uncompensated value of all assets transferred by the individual, on or after the look-back date, divided by the average monthly cost of nursing home services in the State of New Jersey. As of May 2000, the average cost is $5,540. The result of this division shall be rounded down. The penalty period shall begin with the month of the resource transfer. There shall be no limit on the length of the penalty period.
i. For the purpose of determining a penalty period, the transfer of real property shall be considered to have occurred the date the title is recorded or registered with the appropriate office.
. In the case of an asset transfer which occurs during an existing asset transfer penalty period, the penalty for the subsequent transfer shall not begin until the expiration of the previous penalty period.
3. When assets have been transferred in amounts and/or frequencies that would make the calculated penalty periods overlap or structured to run consecutively, the uncompensated value of all of the asset transfers shall be added together and divided by the average cost of nursing home care. This will result in a single penalty period, beginning on the first day of

the month in which the first transfer was made. For example: An individual transfers $15,000 in January, $15,000 in February, and $15,000 in March. Calculated individually, the penalty periods would overlap. Because the three penalty periods overlap, each of the asset transfers shall be added together and divided by the average cost of nursing home care creating a single penalty period beginning on January 1.

4. When assets have been transferred in such a way that the penalty periods would not overlap, or are not structured to run consecutively, each asset transfer shall be treated as a separate event, each with its own penalty period. For example: An individual transfers $12,000 in January, $12,000 in November and $12,000 in March of the following year. The penalty period for the January transfer would be January and February. The penalty for the November transfer would be November and December. The penalty period for the March transfer would be March and April of the following year.

(n) When an individual's income is given or assigned in some manner, such gift or assignment shall be considered an asset transfer. The following standards shall be used to determine the penalty period:

1. Income, in order to be considered transferred, shall have been irrevocably assigned or otherwise unavailable to the individual. If income has been waived or deferred and that waiver or deferral can be reversed, the waived or deferred income shall be considered available to the individual, regardless of whether the income is actually received, and shall be counted in the determination of eligibility.

2. In the event an individual gives up his or her rights to receive a lump sum payment or transfers a lump sum payment in the month it is received, the period of ineligibility shall be based on the amount of the lump sum payment to which he or she was otherwise entitled.

3. In the event a stream of income (that is, income received on a regular basis), such as a pension, is transferred, the county board of social services shall make a determination of the total projected amount of income that has been transferred, based on the individual's life expectancy. This determination shall be based on the most recent life expectancy tables published by the Health Care Financing Administration. In determining the projected amount, the county board of social services shall strictly adhere to the life expectancy tables without adjustment for the individual's medical condition or other factors. The projection shall be based on the value of the income at the time of transfer and there shall be no attempt to account for future cost-of-living adjustments over the life expectancy of the individual.

4. In determining if there has been a transfer of income, the county board of social services need not ascertain the individual's spending habits over the appropriate look-back period. Unless there is a reason to believe otherwise, the county board of social services shall assume that the individual's income was legitimately spent on the normal costs of living. The county board of social services may ask questions of the applicant and/or the applicant's representative concerning past and present sources and levels of income and whether the individual has transferred income to others.

(o) When an asset is held by an individual in common with another person or persons via joint tenancy, tenancy in common, joint ownership, or similar arrangements, the asset (or the affected share of the asset) shall be considered to be transferred by the individual when

any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

1. If the addition of another name to the ownership of an asset does not change the individual's ownership interest, the action does not constitute a resource transfer. For instance, if another name is added to an individual's account with the term "or," the individual shall not be considered to have transferred assets since he or she continues to have unrestricted access to the funds. In the event the newly added owner subsequently withdraws the funds from the account, that action shall be considered to be a transfer by the individual. The transfer shall be considered to have occurred on the date that the funds are withdrawn from the account.

2. If the addition of another name to the ownership of an asset restricts the individual's access, right to sell or otherwise dispose of the asset (for example, the addition of another name requires that the new co-owner(s) agree to the sale or disposal of the asset where no such agreement was necessary before), the addition of the name shall constitute a transfer of assets. The transfer shall be considered to have occurred on the date that the additional name was added to the account. In the case of real property for the purpose of this chapter, if another name is added to a deed, the transfer shall be considered to have occurred the date the new deed is recorded.

3. N.J.A.C. 10:71-4.1 shall apply to determine what portion of a jointly owned resource is presumed to belong to the individual. Any portion belonging to the individual that is withdrawn by another owner shall be considered a transfer of assets. If the individual can satisfactorily establish that the withdrawn funds were, in fact, the sole property of, and were contributed to the account by the other owner, and thus never belonged to the individual, the withdrawal of those funds shall not result in the imposition of an asset transfer penalty.

(p) Annuity provisions shall be as follows:

1. Any annuity purchase in which the entity issuing the annuity is not a commercial financial institution shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits, regardless of the terms of the annuity payout. The entire amount transferred into such an annuity shall be the amount considered in determining eligibility.

2. Any commercial annuity purchased which is not actuarially sound, based on the life expectancy of the individual (as set forth in life expectancy tables published by the Health Care Financing Administration) or term certain (the length of payout is specified and payment does not terminate upon the death of the annuitant) shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits. In the event that an annuity is not actuarially sound at the time of purchase, the amount that shall be considered to have been transferred at less than fair market value shall be that proportion of the annuity purchase price which is not actuarially sound. This shall be the same proportion as the amount by which the pay-out period exceeds the life expectancy of the individual at the time of the annuity purchase. (Life expectancy divided by the pay-out period of the annuity multiplied by the purchase amount of the annuity is subtracted from the total amount of the annuity to determine the uncompensated value.)

i. If an annuity is purchased for a community spouse with any portion of the couple's funds and the annuity purchase price exceeds the amount of the protective share of the community spouse, as determined in accordance with the procedures specified at N.J.A.C.

10:71-4.8(a), the amount in excess of the community spouse's protected share shall be counted in determining the applicant's eligibility.

(q) Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer, the county board of social services shall notify the applicant/beneficiary of his or her right to request an undue hardship exception. An applicant/beneficiary may apply for an exception to the transfer of asset penalty if he or she can show that the penalty will cause an undue hardship to him or herself. The applicant/beneficiary shall provide sufficient documentation to support the request for an undue hardship waiver to the county board of social services within 20 days of notification of the transfer penalty.

1. For the purposes of this chapter, undue hardship shall be considered to exist when:

i. The application of the transfer of assets provisions would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered. Undue hardship may also exist when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life; and

ii. The applicant/beneficiary can irrefutably demonstrate the transferred assets are beyond his or her control and that the assets cannot be recovered. The applicant/beneficiary shall demonstrate that he or she made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets transferred.

2. Undue hardship shall not exist when the application of a transfer penalty merely causes the applicant/beneficiary an inconvenience or restricts his or her lifestyle.

3. In the event that a waiver of undue hardship is denied, neither the Department of Human Services, the Department of Health and Senior Services, nor the county boards of social services shall have any obligation to take any action to assure that payment of services is provided during the penalty period.

4. If the request for undue hardship consideration is denied by the CBOSS, the CBOSS shall notify the applicant of the denial and that the applicant may request a fair hearing in accordance with the provisions of N.J.A.C. 10:49- 10.

10:71-4.11 Trusts

(a) For purposes of this subchapter, effective June 18, 2001, a trust is any legal instrument, device, or arrangement which is similar to a trust, in which a grantor transfers property to an individual or entity with fiduciary obligations (considered to be a trustee for purposes of this section). The grantor transfers the property with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or others. For the purposes of this chapter, a trust shall include, but not be limited to, escrow accounts, annuities, investment accounts, and other similar devices managed by an individual or entity with fiduciary obligations.

(b) The standards set forth in this section shall apply to trusts without regard to:

1. The purposes for which the trust is established;
2. Whether the trustee(s) has discretion or exercises such discretion under the trust;
3. Any restrictions on when or whether distribution can be made from the trust; or

4. Any restrictions on the use of distributions from the trust.

(c) Definitions, for the purposes of this section, shall be as follows:

1. A grantor shall be any individual who creates a trust. This section shall apply only to situations in which the grantor is:

i. The individual;

ii. The individual's spouse;

iii. A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or

iv. A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

2. A revocable trust is a trust which can, under State law, be revoked by the grantor. A trust, which provides that the trust can be only modified or terminated by a court, is considered to be a revocable trust, since the grantor (or his or her representative) can petition the court to terminate the trust. Also, a trust that declares itself to be irrevocable, but which terminates upon conditions relating to the grantor during his or her lifetime, shall be, for the purposes of this section, considered to be revocable. For example, a trust may require a trustee to terminate a trust and disburse the funds to the grantor if the grantor leaves a nursing facility. Such a trust shall be considered to be revocable.

3. An irrevocable trust is a trust which cannot, in any way, be revoked by the grantor.

4. A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust. The term "beneficiary" shall not include the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor, another individual, or individuals, or any combination of any of these parties.

5. For purposes of this chapter, a payment from a trust shall be any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use or occupy real property.

(d) Individuals to whom the trust provisions apply shall include any individual who establishes a trust and who is an applicant or beneficiary of Medicaid. An individual shall be considered to have established a trust if any of his or her assets, regardless of the amount, were used to form part or all of the corpus of the trust and if any of the parties described as a grantor in (c)1 above established the trust, other than by will.

1. When the corpus of a trust includes assets of another person or persons not described in (c)1 above, as well as assets of the individual, the rules apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, the county board of social services shall prorate any amounts of income and resources, based on the proportion of the individual's assets in the trust to those of other persons.

2. When the corpus of a trust includes assets of either an institutionalized spouse as defined in N.J.A.C. 10:71-4.7(b)3 or a community spouse, this section shall apply to the portion of the trust attributable to either spouse for the purposes of determining eligibility for the institutionalized spouse.

(e) Treatment of trusts, for purposes of determining Medicaid eligibility, shall be dependent on the characteristics of the trust. The look-back period for evaluation of resource transfer shall be 60 months. The following are the rules for consideration of various kinds of trusts:

1. In the case of a revocable trust:

i. The entire corpus of the trust shall be counted as a resource available to the individual;

ii. Any payments from the trust made to or for the benefit of the individual shall be counted as income (unless otherwise excludable, see N.J.A.C. 10:71-5.3); and

iii. Any payments from the trust which are not made to or for the benefit of the individual shall be considered assets disposed of for less than fair market value (see N.J.A.C. 10:71-4.10).

2. In an irrevocable trust from which payment can be made under the terms of the trust to or for the benefit of the individual from all or a portion of the trust, the following shall apply to that trust or that portion of the trust:

i. Payments from income or from the corpus made to or for the benefit of the individual shall be treated as income to the individual unless otherwise excludable (see N.J.A.C. 10:71-5.3);

ii. Income on the corpus of the trust which could be paid to or for the benefit of the individual shall be counted as a resource available to the individual;

iii. The portion of the corpus that could be paid to or for the benefit of the individual shall be treated as a resource available to the individual; and

iv. Payments from income or from the corpus that are made, but not to or for the benefit of the individual, shall be treated as a transfer of assets for less than fair market value (see N.J.A.C. 10:71-4.10).

3. In the case of an irrevocable trust from which payments from all or a portion of the trust cannot, under any circumstances, be made to or for the benefit of the individual, all of the trust, or any such portion or income thereof, shall be treated as a transfer of assets for less than fair market value (see N.J.A.C. 10:71-4.10).

i. In treating these portions as a transfer of assets, the date of transfer shall be considered to be the date the trust was established, or, if later, the date on which the right of payment to the individual was foreclosed.

ii. For transfer of assets purposes, in determining the value of the portion of the trust which cannot be paid to the individual, amounts that have been paid, for whatever purpose, shall not be subtracted from the value of the trust on the date the trust was created or, if later, the date that payment to the individual was foreclosed. The value of the transferred amount shall be no less than the value on the date the trust is established or on the date that payment is foreclosed. If additional funds are added to this portion of the trust, those funds shall be treated as a new transfer of assets or less than fair market value.

4. Payments made from a revocable or irrevocable trust to or on behalf of the individual shall include payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment. For example, such payments may include purchase of clothing or other items, such as a radio or television, for the individual. Such payments may also include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home shall also be

considered payments for the benefit of the individual.

i. When a payment to or for the benefit of the individual is made which would not be considered income in the eligibility process, then the payment shall not be counted as income to the individual under this section. For example, payments made on behalf of an individual for medical care are not counted in determining income eligibility for Medicaid, and are therefore not counted as income under these trust provisions.

5. In determining whether payments can or cannot be made from a trust to or for an individual, the county board of social services shall take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust. Any amount in a trust for which payment can be made, no matter how unlikely the circumstance of payment might be or how distant in the future, shall be considered a payment that can be made under some circumstances.

i. For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual and may be subject to a transfer penalty. On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under some circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances and the funds are included.

6. Placement of excluded assets in trust, with the exception of a home, shall not result in a penalty of ineligibility because the transferred asset is not an asset for transfer purposes. However, a home, whether excluded or not, when transferred into a trust shall be presumed to have been transferred for the purposes of qualifying for Medicaid.

(f) Transfer to a trust (or similar instrument, including an annuitized trust) for the sole benefit of a community spouse shall be treated in accordance with the provisions of (e) above. If the trust is established by either member of the couple (using at least some of the couple's assets), the trust shall be reviewed by the county board of social services for availability of resources, in accordance with (e) above. If the payment from such a trust shall be considered an available resource to either spouse, the trust shall be included as a countable resource in determining Medicaid eligibility for the institutionalized spouse pursuant to N.J.A.C. 10:71-4.8.

(g) The trust provisions shall not apply to the following trusts so long as the trust document meets all the requirements set forth in this chapter:

1. A special needs trust, that is, a trust containing the assets of a disabled individual and which is established prior to the time the disabled individual reaches the age of 65 and which is established for the sole benefit of the disabled individual by a parent, grandparent, legal guardian of the disabled individual, or a court, may be excluded from the rules regarding the treatment of a trust. To qualify for the exclusion, the trust shall contain the following provisions:

i. The trust shall be identified as an OBRA '93 trust established pursuant to 42 U.S.C. §

1396p(d)(4)(A).

(1) The trust shall not contain any provisions intended to give anyone or a Court the power to alter the form of the trust from an individual trust to a "pooled trust" under 42 U.S.C. § 1396p(d)(4)(C). Similarly, there shall be no provisions permitting the trust to be altered for any other reasons.

ii. The trust shall specifically state that the trust is for the sole benefit of the trust beneficiary.

(1) Only trusts which are intended for the sole benefit of the disabled individual are special needs trusts. Any trust which provides benefits to other persons shall not be considered an individual special needs trust. If expenditures are made from the trust which shall also incidentally provide an ongoing and continuing benefit to other persons, those other persons who also benefit shall contribute a pro-rata share to the trust for the subsequent expenses associated with their use of the acquisition,

(A) For example, if the trust acquires housing for the benefit of the trust beneficiary, and other family members also live in that house, the trust document shall provide that the trustee shall require and collect a pro rata contribution for the expenses of uses incurred, and shall return such contribution to the trust. Such collections shall be reflected in the annual required trust accounting. Any property acquired by the trust shall be titled solely in the trust's name. In addition, unless the trust is given equity in any improvements to real property, the trust shall not pay for upkeep, property taxes or other expenses associated with the property or any additions to the existing property.

iii. The trust shall specifically state that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any Federal, State or other governmental entity for which the beneficiary may otherwise be eligible or which the beneficiary may be receiving.

(1) If the trust provides for food, clothing or shelter, such expenditures shall be considered income under Social Security and Medicaid eligibility rules.

(2) It may be permissible for the trust to acquire property which is used to provide shelter for the trust beneficiary, but the trustee shall take care to ensure that such acquisitions do not create unintended problems (such as disqualifying someone for Federal benefits). Additionally, parents shall not be relieved of their duty to support their minor child, if they are capable of doing so. A minor's funds in a trust shall not be expended on routine support, unless the parents' income is insufficient for these expenses. N.J.S.A. 3B:12-43.

iv. The trust shall specifically state the age of the trust beneficiary, that the trust beneficiary is disabled within the definition of 42 U.S.C. § 1382c(a)(3), and whether the trust beneficiary is competent at the time the trust is established.

(1) If the trust beneficiary is a minor, the trustee shall execute a bond to protect the child's funds or shall get a court's permission not to do so.

(2) If there is some question about the trust beneficiary's disability, independent proof may be required.

(3) If the trust beneficiary is a minor, the trust shall state whether the trust beneficiary is expected to be competent at his or her majority.

v. The trust shall specifically identify, in an attached schedule, the source of the initial trust property and all assets of the trust. If the trust is being established with funds from the proceeds of a settlement or judgement subsequent to the bringing of a legal cause of action,

Medicaid's claim for its expenditures that are related to the cause of action shall be repaid immediately upon the receipt of such proceeds and prior to the establishment of the trust.

(1) Subsequent additions made to the trust corpus shall be reported to the appropriate eligibility determination agency. Subsequent additions to the trust (other than interest on the corpus) shall cease when the trust beneficiary reaches age 65, or shall be subject to transfer provisions.

(2) If subsequent additions are to be made to the trust corpus with funds not belonging to the trust beneficiary, it shall be understood that those funds are a gift to the trust beneficiary and cannot be reclaimed by the donor.

vi. If the trust makes provisions which are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the State's right to reimbursement or to recoup incorrectly paid benefits.

vii. The special needs trust shall state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary, or by a court.

(1) The trust shall identify the grantor/settlor by name and as the parent, grandparent, legal guardian, or court. A court can be named as the grantor, if the trust is established pursuant to a settlement of a case before it, or if the court is otherwise involved in the creation of the trust.

viii. The trust shall specifically state that it is irrevocable. Neither the grantor, the trustee(s), nor the beneficiary shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to alter, amend, revoke, or terminate the trust or any of its terms or to designate the persons who shall possess or enjoy the trust estate during his/her lifetime.

(1) Notwithstanding the irrevocability provision above, the trust can state that "the trust shall be irrevocable except that the trust may be amended as necessary to conform with the requirements of 42 U.S.C. 1396p and/or state law."

ix. The trustee shall be specifically identified by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve. The Bureau of Administrative Control, Division of Medical Assistance and Health Services, as well as the trust beneficiary and/or guardian, shall be given prior notice if there is a change in the trustee.

x. The trust shall specifically state that the trustee shall fully comply with all State laws, including the Prudent Investor Act, N.J.S.A. 3B:20- 11.1 et seq. The trust shall provide that the trustee cannot take any actions not authorized by, or without regard to, State laws. If the trust gives the trustee authorization or power not provided for in the Prudent Investor Act, an accompanying letter shall provide an explanation for each such authorization or power.

xi. The trust shall specifically state that the trustee shall be compensated only as provided by law (N.J.S.A. 3B:18-1 et seq.) If the trust identifies a guardian, the trust shall specifically identify him or her by name. A guardian shall be compensated only as provided by law. The parent of a minor child shall not be compensated from the trust as the child's guardian.

(1) If an adult beneficiary is not competent, the trust shall specifically state that the "guardianship protections for the incompetent's funds which are required by New Jersey law and Court rules are incorporated by reference into this trust." The trustee shall either file a bond or shall get the Court's permission not to do so.

xii. The trust shall specifically state that, upon the death of the primary beneficiary, the State will be notified, and shall be paid all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of the beneficiary. The trust shall comply fully with this obligation under the statute to first repay the State, without requiring the State to take any action except to establish the amount to be repaid. Repayment shall be made to the Treasurer, State of New Jersey, and shall be sent to the Division of Medical Assistance and Health Services, to the attention of the Bureau of Administrative Control, PO Box 712, Trenton, New Jersey 08625-0712, or to any successor agency.

xiii. If there is a provision for repayment of other assistance programs, the trust shall specifically state that the Medicaid Program shall be repaid prior to making repayment to any other assistance programs.

xiv. The trust shall specifically state that if the beneficiary has received Medicaid benefits in more than one state, each state that provided Medicaid benefits shall be repaid. If there is an insufficient amount left to cover all benefits paid, then each state shall be paid its proportionate share of the amount left in the trust, based upon the amount of support provided to the beneficiary.

xv. No provisions in the trust shall permit the estate's representative to first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in (g)1xii, xiii and xiv above have been made shall be considered available for other expenses or beneficiaries of the estate. The trust may provide for a prepaid burial plan, but shall not state that it will pay for reasonable burial expenses after the death of the trust beneficiary.

xvi. The trust shall specify that a formal or informal accounting of all expenditures made by the trust shall be submitted to the appropriate eligibility determination agency on an annual basis.

xvii. The State shall be given advance notice of any expenditure in excess of $5,000, and of any amount which would substantially deplete the principal of the trust. Notice shall be given to the Division of Medical Assistance and Health Services, Bureau of Administrative Control, PO Box 712, Mail Code 6, Trenton, New Jersey 08625-0712, or any successor agency, 45 days prior to the expenditures.

xviii. New Jersey rules and laws do not permit a trust to create a will for an incompetent or a minor. The money creating the trust, any additions and/or interest accumulated, cannot be left to other parties, but shall pass by intestacy. The trust shall not create other trusts within it.

2. A pooled trust is a special needs trust, containing the assets of a disabled individual, which meets the following conditions:

i. The trust shall be established and managed by a non-profit association;

ii. A separate account shall be maintained for each beneficiary of the trust, but for purposes of investment and management of the funds, the trust may pool the funds from those accounts;

iii. Accounts in the trust shall be established solely for the benefit of the disabled individual by the individual, by a parent, grandparent, or legal guardian of the individual, or by a court;

iv. To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust shall pay to the State of New Jersey the amount remaining in the account, up to an amount equal to the total amount of medical

assistance paid under Title XIX of the Social Security Act on behalf of the individual. To meet this requirement, the trust shall include a provision specifically providing for such payment; and

v. Funds of an individual 65 or older which are transferred to a pooled trust shall be subject to the transfer penalty provisions contained in N.J.A.C. 10:71-4.7.

(h) Title XIX of the Social Security Act (42 U.S.C. § 1917(d)(4)(B)) provides for an exemption from the trust provisions for qualified income trusts (also known as Miller trusts). Special provisions for this form of trust apply, under the law, only in those states which do not provide medically needy coverage for nursing facility services. Because New Jersey does cover services in nursing facilities under the medically needy component of the Medicaid program, the establishment of a qualified income trust shall be presumed to be an asset transfer for the purposes of qualifying for Medicaid. This presumption shall apply whether the individual is seeking nursing facility services or home and community based services under one of the waiver programs.

(i) Upon the denial of eligibility or the termination of long-term care level services due to the application of these trust provisions, the county board of social services shall notify the applicant/beneficiary of his or her right to request an undue hardship exception. An applicant/beneficiary may apply for an exception to these trust provisions if he or she can show that the transfer will cause an undue hardship to him or herself. The applicant/beneficiary shall provide sufficient documentation to support the request for an undue hardship waiver to the county board of social services within 20 days of notification of the denial of eligibility or termination of benefits due to these trust provisions.

1. For the purposes of this chapter, undue hardship shall be considered to exist when:

i. The application of the trust provisions would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered. Undue hardship may also exist when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life; and

ii. The applicant/beneficiary can irrefutably demonstrate the assets placed in trust are beyond his or her control and that the asset cannot be recovered. The applicant/beneficiary shall demonstrate that he or she made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets placed in trust.

2. In the event that a waiver of undue hardship is denied, neither the Department of Human Services, the Department of Health and Senior Services, nor the county boards of social services shall have any obligation to take any action to assure that payment of services is provided during the penalty period.

3. If the request for undue hardship consideration is denied by the county board of social services, the county board of social services shall notify the applicant of the denial and that the applicant may request a fair hearing in accordance with the provisions of N.J.A.C. 10:49-10.

END OF SUBCHAPTER 4

SUBCHAPTER 5. INCOME

10:71-5.1 Income; financial eligibility standards

(a) As a condition of eligibility for the Medicaid Only Program, applicants must comply with the income standards set forth in this subchapter (see N.J.A.C. 10:71-5.6).

(b) Income defined: For the purpose of this program, income shall be defined as receipt, by the individual, of any property or service which he/she can apply, either directly or by sale or conversion, to meet his/her basic needs for food, shelter,or clothing. All income, whether in cash or in-kind, shall be considered in the determination of eligibility, unless such income is specifically exempt under the provisions of N.J.A.C. 10:71-5.3

1. Availability of income: In order to be considered in the determination of eligibility, income must be "available." Income shall be considered available to an individual when:

i. With the exception of income from self-employment, the individual actually receives the income;

ii. With the exception of income from self-employment, the income becomes payable but is not received by the individual due to his/her preference for voluntary deferment;

iii. Income has been deemed available to the applicant (see N.J.A.C. 10:71-5.5 regarding the deeming of income);

iv. Net earnings from self-employment have been determined in accordance with N.J.A.C. 10:71-5.4(a)2.

2. Earned income: Earned income shall be defined as payment received by an individual for services performed as an employee, or the net earnings as the result of self-employment. When the individual is both employed as self- employed, earned income shall consist of gross wages (or salary, etc.) plus any net earnings from self-employment.

3. Unearned income: Unearned income shall be defined as any income which is not coincident with the provisions of (b)2 above. This definition includes deemed income (see N.J.A.C. 10:71-5.5).

(c) The grandfather clause: An individual (including an essential person) meeting the criteria delineated in N.J.A.C. 10:71-4.5(e) may have his/her income eligibility determined in accordance with the procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974).

10:71-5.2 Determination of countable income

(a) Countable income shall be determined by adding the applicant's nonexempt unearned income (less appropriate exclusions) to his/her earned income (less appropriate exclusions).

(b) Procedures regarding the determination of income eligibility shall be as follows:

1. Determination of initial income eligibility shall be based on all earned and unearned income which has or will be received during the month for which application is made, beginning with the first day of such month, except that quarterly, semiannual, or annual payments shall be prorated in accordance with (b)2 below. (See N.J.A.C. 10:71-5.3(a)15

regarding exclusion of student earnings.)

2. The following shall apply to income received other than monthly:

i. Income received weekly shall be multiplied by 4.333 to determine the monthly amount; biweekly income shall be multiplied by 2.167. (If earned income is irregular, the initial determination shall be based on the average of the amounts received for any four weeks within the 10 week period which includes the five weeks immediately before and after the date of application.)

ii. When income received on a quarterly, semi-annual, or annual basis is of sufficient amount to affect the individual's eligibility, it shall be prorated as a monthly amount and entered on the Medicaid Eligibility Worksheet (Form PA-1E) accordingly. (See also N.J.A.C. 10:71-5.4(a)11, regarding lump-sum payments.)

3. The period of income eligibility begins with the month in which application is made and continues until the scheduled redetermination, or until a change in status or income occurs which requires an earlier redetermination. (See N.J.A.C. 10:71-8.1(a), regarding determination of continuing eligibility.)

4. At the time of application, the applicant shall identify any income which he or she receives periodically (less frequently than once a month) or anticipates receiving prior to the time of redetermination.

5. In situations where earned or unearned income is received irregularly or in irregular amounts, redetermination shall be made as frequently as necessary. The individual shall be advised of his or her responsibility to report significant changes in income. (See N.J.A.C. 10:71-5.3(a)12 regarding exclusion of certain irregular income.)

10:71-5.3 Income exclusions

(a) Only the following income shall be excluded in the determination of countable income. Income exclusions shall be applied to unearned income first, then to earned income as appropriate. Exclusions shall be applied in the order of their appearance in this section.

1. Monies received as a result of the sale of a resource shall be excluded. These monies shall be treated as a resource (see N.J.A.C. 10:71-4.2 and N.J.A.C. 10:71-4.4(b)8ii).

2. Monies received as a result of the settlement of a casualty insurance claim, if such settlement is intended as compensation for the loss or destruction of a previously excludable resource, shall be excluded (see N.J.A.C. 10:71-4.4(b)8i).

3. Third-party payments for medical care or services, including room and board furnished during medical confinement, shall be excluded.

4. The value of social services (for example, advice, training, consultation) performed by any governmental or private agency shall be excluded.

5. The value of food stamps shall be excluded.

6. All loans which are actually repayable shall be excluded.

i. Regular contributions to an individual by his or her family, which are made over an extended period of time and which would be impossible to repay given the individual's current and/or future financial status, shall not be considered loans. Contributions of this nature shall be treated as income in accordance with N.J.A.C. 10:71-5.2.

7. Benefits received under the following Federal programs shall be exempt:

i. The value of benefits received under the Federal WIC program shall be exempt.

ii. The value of meals provided under the National School Lunch Act shall be exempt.

iii. Training incentive payments made under the Comprehensive Employment Training Act (CETA) of 1973 shall be exempt.

iv. Payments received under Title II of the Uniform Relocation and Real Property Acquisition Policies Act of 1970 shall be exempt.

v. Payments received for services performed in connection with the Domestic Volunteer Service Act of 1973 shall be exempt. Such programs include the Foster Grandparents Program, Older Americans Community Service Program, the Retired Senior Volunteer Program (RSVP), the Service Corps of Retired Executives (SCORE), Volunteers in Service to America (VISTA), the Active Cooperative Volunteer Program (AVP), the Active Corps of Executive (ACE), and other programs which are coordinated by the Federal ACTION agency.

vi. Payments made by the Disaster Assistance Administration shall be exempt.

vii. The value of assistance to children under the Child Nutrition Act of 1966 shall be exempt.

viii. Payments from Home Energy Assistance (HEA) and the Crisis Intervention Program shall be exempt.

ix. Payments received from the Youth Incentive Entitlement Pilot Projects, Youth Community Conservation and Improvement Projects, and the Youth Employment and Training Programs under the Youth Employment and Demonstration Projects Act of 1978 shall be exempt. However, payments from the Adults Conservation Corps under that Act or any other payments under the Comprehensive Employment and Training Act (CETA) of 1973 (with the exception of (a)6iii above) may not be excluded.

x. The amount of the annual cost-of-living increase in Social Security benefits for those individuals who became ineligible for Supplemental Security Income (SSI) solely as a result of SSA cost-of-living increases after June 30, 1977 shall be exempt. Individuals eligible for this exemption are entitled to an additional exemption of the dollar amount of all SSA cost-of-living increases subsequent to that increase which created their SSI ineligibility.

xi. For certain individuals, the dollar amount of the October 1972, 20 percent cost-of-living increase in Social Security benefits shall be exempt. In order to qualify for this exemption, the individual must have been, for the month of August 1972:

(1) Eligible for or receiving cash assistance under Old Age Assistance, AFDC, Aid to the Blind, or Disability Assistance (including persons who were eligible for such assistance but not receiving such assistance because they had not applied for it or because they were residents in medical or intermediate care facilities); and

(2) Entitled to a monthly insurance benefit under Title II of the Social Security Act (RSDI).

8. That part of the proceeds of a life insurance policy which is used to pay the last illness and burial expenses of the insured shall be excluded.

i. Last illness and burial expenses shall include related hospital, medical, funeral, burial plot, interment expenses, and related costs.

9. Refunds on taxes for food, real property, or income shall be exempt.

10. That portion of a grant, scholarship, or fellowship which is to be used to pay tuition and mandatory fees (as defined by the educational institution) shall be excluded.

11. The value of agricultural produce, if raised for home consumption, shall be excluded.

12. Certain irregular and/or infrequently received income shall be excluded as follows:

i. Unearned income which totals $60.00 or less per quarter (any consecutive three-month

period), and which is received less frequently than twice per quarter or cannot be reasonably anticipated shall be excluded.

ii. Earned income which totals $30.00 or less per quarter (any consecutive three-month period), and which is received less frequently than twice per quarter or cannot be reasonably anticipated shall be excluded.

13. Monies paid to an individual as compensation for the care of a legally assigned foster child shall be excluded. (This income is not excludable if the child is an eligible individual in his or her own right, or if he or she does not reside in the home of the eligible individual(s).)

14. One-third of the amount received as child support from an absent parent shall be excluded.

15. Income received as compensation for services performed as an employee, or from self-employment, by an unmarried student who is under 22 years of age, shall be excluded to the extent that such income does not exceed $1,200 in a calendar quarter and/or $1,620 per calendar year.

i. A person shall be considered a student if he or she meets the following criteria:

(1) He or she is enrolled in a course or courses of study and attends to the extent required for continued enrollment. Specifically, a person must attend:

(A) A college or university at least eight semester or quarter hours weekly; or

(B) A secondary school at least 12 clock hours weekly; or

(C) A course of vocational or technical training (other than at a secondary school, college, or university) designed to prepare the student for gainful employment involving shop practice, at least 15 clock hours a week; or without shop practice, at least 12 clock hours per week; or

(D) Less than the appropriate requirements in (a)15i(1)(A), (B), and (C) above, if it is determined that there are extenuating circumstances beyond the control of the student and he/she is pursuing a course of study comparable to the requirements of (a)15i(1)(A), (B), and (C) above.

(2) A student shall be considered in regular attendance if he or she is engaged in home study provided by a secondary school, college, university, or governmental agency, and a home visitor or tutor supervises the study or training. For purposes of this section, government-sponsored courses in the various self-improvement and anti-poverty programs are considered to be for the purposes of preparing the student for gainful employment.

(3) A student shall be considered in regular attendance during normal vacation periods if he or she is in regular attendance in the month immediately preceding and immediately following the vacation period.

(4) A student shall be considered to be in regular attendance for the month in which he or she completes or discontinues his or her school or training program.

16. Benefits provided under the State's Lifeline Utility Credit Program shall be excluded.

17. Interest on or appreciation in value of burial funds excluded from consideration as resources at N.J.A.C. 10:71-4.4(b)9 shall be excluded from income.

18. The first $20.00 per month of income, other than income received as a VA pension based upon need, shall be excluded. This exclusion shall be applied first to unearned income, and any remaining amount of exclusion then applied to earned income. In the determination of countable income of a couple, this $20.00 exclusion is applied to the combined income of both.

19. Earned income, in the amount of $65.00 per month plus one-half of the remaining sum, shall be excluded. In the determination of countable income of a couple, this exclusion applies to the combined earned income of both.

20. In the case of blind persons only, all expenses reasonably attributable to the earning of income shall be excluded.

21. In the case of blind or otherwise disabled persons, the amount of money which is needed to achieve an approved plan of self-support shall be excluded.

i. In order for this exclusion to apply, the plan of support must have been approved, in writing, by the Division of Vocational and Rehabilitation Services or the Commission for the Blind and Visually Impaired. The plan must also be current.

10:71-5.4 Includable income

(a) Any income which is not specifically excluded under the provisions of N.J.A.C. 10:71-5.3 shall be includable in the determination of countable income. Such income shall include, but is not limited to, the following:

1. Wages, salaries, tips, and commissions: Any and all compensation for services performed as an employee shall be included as earned income.

2. Income from self-employment: Net adjusted income from self-employment shall be included as earned income.

i. Determination of net adjusted income from self-employment: In the determination of net adjusted income, IRS rules shall apply.

(1) Individual business: Net adjusted income shall be the amount of gross income, less all allowable deductions attributable to the trade or business.

(2) Partnership: Net adjusted income shall be the individual's distributive share of the trade or business in which he/she is a partner.

ii. Annualization of income: If income from self-employment is received on other than a monthly basis, such income shall be averaged over the most recently ended taxable year in order to determine the average monthly or quarterly income to the individual, with the following exceptions:

(1) Seasonal self-employment: An individual whose income from seasonal self-employment is supplemented by income from employment and/or other sources during the balance of the year shall not have his/her self- employment income annualized. Income from self-employment shall be averaged only over the period in which it is intended to cover.

3. Annuities, pensions, and other benefits: Payments received in an annuity, pension, retirement or disability benefits, workers or unemployment compensation, veteran's Social Security (gross income), or strike benefits shall be included as unearned income.

i. Social security income: SSA gross income shall be defined as the actual amount of the check, plus any premium deduction made under the Supplemental Medical Insurance Program (SMI on Part B Medicare).

4. Educational grants and loans: Scholarships, educational grants, fellowships, and veteran's educational benefits shall be included as unearned income, except as provided in N.J.A.C. 10:71-5.3(a)10.

5. Support, alimony, and inheritances: Support, alimony, and inheritances, in the amounts actually received, shall be included as unearned income except as provided in N.J.A.C. 10:71-5.3(a)14.

6. Vendor payments: Cash payments, except those for medical costs, which are made on behalf of the individual by an organization or other third party shall be included as unearned income.

7. Proceeds of life insurance policies: Payments made as the result of the settlement of a life insurance policy claim shall be included as unearned income except as provided in N.J.A.C. 10:71-5.3(a)8.

8. Prizes, gifts, and awards: Cash or in-kind payments which are received as prizes, gifts, or awards shall be included as unearned income. (Occasional gifts, such as Christmas presents, with a value of $20.00 or less, are excluded.)

i. Gift defined: A gift shall be defined as any payment which is neither given as compensation for services or other consideration, nor as satisfaction of any legal obligation to the beneficiary of the gift.

ii. Value of in-kind prizes, gifts, or awards: The value of an in-kind prize, gift, or award shall be its cash value.

9. Dividends, interest royalties: Dividends, interest, and royalties shall be included as unearned income.

10. Rental income and income from roomer-boarder: The amount remaining, after all the costs (except depreciation costs) of producing the income have been deducted, shall be included as unearned income.

11. Lump-sum payments: A lump-sum payment shall be included as income (either earned or unearned, as appropriate) either in the month in which it is received or prorated over three months when the payment exceeds the individual's monthly deficit, except as follows:

i. No portion of a cash reward provided to any individual by the Division by providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

12. Support and maintenance furnished in-kind (community cases): Support and maintenance encompasses the provision to an individual of his or her needs for food, clothing, and shelter at no cost or reduced value. Persons determined to be "living in the household of another" in accordance with N.J.A.C. 10:71- 5.6 shall not be considered to be receiving in-kind support and maintenance as the income eligibility levels have been reduced in recognition of such receipt. Persons not determined to be "living in the household of another" who receive in-kind support and maintenance shall be considered to have income in the amount of:

$190.67 for an individual

$276.33 for a couple

i. In the event the individual/couple can demonstrate that the actual value of in-kind support and maintenance is less than the assigned value, the lesser value shall be counted as unearned income.

13. Support and maintenance furnished in-kind (other living situations):

i. Title XIX facilities: In-kind support and maintenance is not counted in cases in which the individual is considered institutionalized for program purposes (i.e., the individual's eligibility is determined under the Medicaid "Cap").

ii. Private nonprofit domiciliary care facility: The value of in-kind support and maintenance provided an individual in a nonprofit residential care facility is excluded when all the

following conditions are met:

(1) The facility is not a public facility. A public facility is one which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(2) The facility, or the distinct portion in which the individual resides, is neither a Title XIX in-kind nor an institution for educational or vocational training.

(3) The facility is tax-exempt under Section 501(c) or (d) of the Internal Revenue Code.

(4) The facility (or organization controlling it) provides support and maintenance to the individual but does not receive payment for that part to be excluded or receives such payment from a private nonprofit organization which is also tax exempt under Section 501(c) or (d) of the Internal Revenue Code.

(5) The nonprofit facility or nonprofit organization has not undertaken an express obligation to furnish full support and maintenance to the individual. An express obligation to provide full support and maintenance exists when an institution agrees to provide lifetime care in return for a specified lump sum payment and there is no requirement for any current or future payment. An express obligation also exists if, as a result of the membership of the individual or of a relative, in an organization (fraternal or religious order, union, etc.) there exists a written document requiring the facility to provide lifetime care regardless of payment provided.

(6) If the criteria in (a)13ii(1)-(5) above are not met, the value of support and maintenance is determined in accordance with (a)13iii below.

iii. Other nonmedical facilities:

(1) Facility is proprietary (private for-profit) or private non-profit and no third party pays: The value of in-kind support and maintenance is excluded from income if it is provided by such a facility, no third party payment is made for it, and:

(A) The individual makes some payment which the facility accepts as payment in full (even though its usual charge may be higher); or

(B) The individual contracts a written indebtedness to the facility for his/her support and maintenance and the facility accepts the amount of the debt plus the individual's payment, if any, as payment in full.

(2) Facility if proprietary or private nonprofit and third party pays: When a proprietary (private for-profit) or private nonprofit facility provides support and maintenance to an individual because a third party pays the facility on that individual's behalf, that individual is receiving in- kind support and maintenance. The value of the in-kind support and maintenance is determined in accordance with (a)12 above.

(3) Other situations regardless of third-party payment: In other types of facilities, support and maintenance provided by that facility is unearned income to the individual in accordance with (a)12 above.

(b) Countable income: Income remaining after appropriate income exclusions shall be applied toward the applicable income eligibility standard. The applicant's living arrangement affects the method of treatment of income and its relationship to the standards as stated in the variations appearing below.

1. Applicant/beneficiary living alone: If the applicant/beneficiary lives alone, only his or her countable income shall be applied to the appropriate income standard.

2. Applicant/beneficiary couple: In the case of an applicant/beneficiary couple, living

together, the total amount of husband's and wife's countable income shall be combined and applied to the appropriate income eligibility standard for a couple. Such individuals will continue to have their countable income combined until they have been separated for a period of six months.

i. One member of couple institutionalized: When one member of an applicant/beneficiary couple is institutionalized and the other remains in the community, no income of the community spouse will be used in the determination of income eligibility beginning in the month of admission into a Title XIX facility.

ii. Institutionalized couple: When an applicant/recipient couple is institutionalized in the same facility, the gross income of each individual is combined and applied to an amount equal to two times the Medicaid "Cap." If, however, the applicant/recipient couple is institutionalized in separate facilities, the income of each is applied individually to the Medicaid "Cap."

3. Applicant/beneficiary living with ineligible spouse: if the applicant/beneficiary lives with an ineligible spouse, the income of the ineligible spouse is deemed to the applicant/beneficiary (see N.J.A.C. 10:71-5.5). Such individual's income shall continue to be deemed until the husband and wife have been separated for one month. At such time the individuals will be considered to be living alone and deeming shall cease.

i. Effect of institutionalization: Income of the community spouse shall not be considered in the determination of income eligibility of the institutionalized individual beginning with the month of admission into a Title XIX facility.

4. Applicant/beneficiary unmarried and under 18 years of age, living with parents: If the applicant/recipient is an unmarried child under 18 years of age who lives with his or her parents (including stepparents), the income of the parents is deemed to the child (see N.J.A.C. 10:71-5.5(c)3). Such deeming will cease when a child has ceased living with his/her parents for a period of one calendar month.

i. Child not living with parents due to institutionalization: If a physician has certified that the child's duration of stay in a Title XIX facility (or a combination of such facilities) is expected to be a full calendar month or more, such child shall be considered to be not living with his/her parents and deeming shall cease at the time of such certification.

10:71-5.5 Deeming of income

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse or is a child residing in the same household with his or her parent(s) or spouse of the parent, the income of the ineligible spouse or parent(s) is considered in the determination of financial eligibility. The amount included as income to the applicant/beneficiary, whether or not it is actually available, is called deemed income and is computed as described in N.J.A.C. 10:71-5.5(c), (d), (e) and (f).

1. Child: For the purpose of this section, a child is an individual who is not married and is under the age of 18 (see N.J.A.C. 10:71-5.3(a)15i regarding earnings of a child who is a student). Additionally, deeming of parental income to a blind or disabled child ceases when the child reaches age 18.

2. Parent: A parent, for deeming purposes, is a natural or adoptive parent or stepparent living in the same household as an applicant/beneficiary child. However, death or divorce of the natural or adoptive parent terminates deeming responsibility of a stepparent.

(b) Items not included in deeming: In determining the income of an ineligible spouse, parent and/or spouse of a parent, or income of any ineligible children in the household, the following are not included as income:

1. Any assistance based on need and any income considered in the determination of the amount of such assistance;
2. That portion of any grant, scholarship, or fellowship, used to pay the cost of tuitions and fees at an educational institution or costs of vocational technical training designed to prepare the individual for gainful employment;
3. Amounts received for foster care of an ineligible child;
4. The value of food stamps or U.S. Department of Agriculture donated foods (e.g., supplemental food programs);
5. Home produce grown for personal consumption;
6. Refund of taxes paid on income, real property, or food purchased by the family;
7. Such income used to comply with the terms of court-ordered support and support payments pursuant to Title IV-D of the Social Security Act;
8. The value of in-kind support and maintenance furnished to the ineligible spouse, ineligible parent(s) or ineligible spouse of a parent, and ineligible children in the household;
9. Income and benefits received under certain Federal programs described in Section N.J.A.C. 10:71-5.3(a)7;
10. The earned income of an ineligible child who is a student (subject to the limitations of N.J.A.C. 10:71-5.3(a)15, unless the child actually makes the income available to the family);
11. Income necessary for a plan to achieve self-support but only if the spouse's or parental income is actually being used according to the plan to achieve self-support.

(c) Deeming of income from spouse to spouse: If the applicant's/beneficiary's own countable income, as determined in accordance with N.J.A.C. 10:71-5.2, less appropriate exclusions in N.J.A.C. 10:71-5.3, exceeds the applicable Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71- 5.6(c)5, the applicant/beneficiary is financially ineligible for Medicaid Only based on his or her own countable income, and there is no deeming. However, if the applicant's/beneficiary's own countable income renders him or her financially eligible for Medicaid Only, the following steps shall be used to compute deemed income:

1. Step 1: Calculate separately the ineligible spouse's earned and unearned income, less any income excluded in accordance with N.J.A.C. 10:71-5.5(b). Do not combine the two totals.
2. Step 2: Determine the living allowance for each ineligible child not receiving public assistance, by subtracting the child's countable income from the amount of the living allowance for an ineligible child in Table A, Figure 1.
3. Step 3: Subtract the living allowance for each ineligible child, determined in Step 2 above, from the unearned income of the ineligible spouse. Subtract any remaining living allowance from the earned income of the ineligible spouse. For any ineligible child receiving public assistance, no living allowance may be subtracted.
4. Step 4: If the total remaining income (earned plus unearned) of the ineligible spouse is equal to or less than the appropriate remaining income amount in Table A, Figure 2, no

income is available for deeming to the applicant/beneficiary. The deeming process stops.

i. Determine the beneficiary's income eligibility for Medicaid Only by comparing his or her own countable income to the appropriate Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71-5.6(c)5.

5. Step 5: If Step 4 above does not apply, and the ineligible spouse's remaining total income (earned plus unearned) exceeds the appropriate remaining income amount in Table A, Figure 2, the deeming process continues and the applicant/beneficiary and his or her ineligible spouse are treated as a couple. The following deeming steps shall be used to compute the couple's countable income:

i. Add the ineligible individual's remaining unearned income after the deduction of the living allowance for the ineligible child(ren) to all of the beneficiary's unearned income. Determine the value of in-kind support and maintenance in deeming situations, in accordance with N.J.A.C. 10:71- 5.4(a)12.

(1) Do not apply the $20.00 general income exclusion to the beneficiary individual's income before combining the income.

ii. Add the ineligible individual's remaining earned income after deduction of the living allowance for the ineligible child(ren) to all of the applicant's/beneficiary's earned income.

iii. Treat the two totals of unearned and earned income in the same manner as those of an eligible couple. Apply appropriate income exclusions and compute the couple's countable income as follows:

(1) First, subtract the $20.00 general income exclusion from the total unearned income. Then, subtract any unused portion of the general income exclusion from the total earned income, if any.

(2) From the remaining earned income, subtract $65.00 (work expense allowance) and one-half of the remainder of earned income.

(3) Add the remaining earned and unearned income together to arrive at the couple's total countable income.

6. Step 6: If the couple's (applicant/beneficiary and ineligible spouse) remaining countable income is less than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially eligible for Medicaid Only. If the couple's remaining income is equal to or greater than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially ineligible for Medicaid Only.

(d) Deeming of income to spouse and child(ren): In situations when an ineligible individual is subject to deeming of his or her income to both an applicant/beneficiary spouse and an applicant/beneficiary child, the following deeming procedures are used:

1. Step 1: Determine the amount of income, if any, to be deemed to the applicant/beneficiary spouse in accordance with the procedures in N.J.A.C. 10:71-5.5(c).

2. Step 2: If, after deeming of income from the ineligible spouse, the adult applicant/beneficiary is financially eligible for Medicaid Only, there is no income available for deeming to the applicant/beneficiary child(ren). The deeming process stops.

3. Step 3: If, in the process of deeming of income to the applicant/beneficiary spouse, such spouse becomes financially ineligible for Medicaid Only, that portion of deemed income that exceeds the eligibility level in Table A, Figure 3, for the appropriate living arrangement for the adult applicant/beneficiary shall be deemed to any child applicant/beneficiary. This

income is treated as unearned income to the child.

4. Step 4: If there is more than one child applicant/beneficiary in the household, divide the deemable income equally among them. However, income is not deemed to any child in excess of that amount which, in combination with his or her own countable income, creates financial ineligibility for the child. That portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement, shall be available for deeming equally to any other applicant/beneficiary child(ren) in the household (in accordance with Step 5 below) in addition to their equal shares of the total parental deemable income.

5. Step 5: Combine any income deemed to the eligible child together with any countable income of the eligible child.

i. First, subtract the $20.00 general income exclusion from the child's unearned income.

ii. If the child's total income is less than the appropriate income eligibility standard in Table B, the child is financially eligible for Medicaid Only.

iii. If the child's total income is greater than the appropriate income eligibility standard in Table B, the child is financially ineligible for Medicaid Only, and that portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement for the applicant/beneficiary child, shall be available for deeming equally to any other applicant/beneficiary children in addition to their equal shares of the total deemable income.

(e) Deeming of income from a parent (and spouse of a parent) to a child: The computation methods for deeming of income from an ineligible parent (and spouse of a parent) to a child differ depending on the type of parental income.

1. Step 1: Determine the total monthly parental income, both earned and unearned (separately), less any income excluded in N.J.A.C. 10:71-5.5(b). Do not combine the two totals.

i. Determine the living allowance for each ineligible child not receiving public assistance, by subtracting the child's countable income from the amount of the living allowance for an ineligible child in Table A, Figure 1. No allowance may be deducted for a child receiving public assistance.

ii. Subtract the living allowance for each ineligible child, determined in (e)1i above, from the unearned income of the parent(s). Subtract any remaining living allowance from the earned income of the parent(s).

iii. The remaining parental income should be treated in accordance with the procedures of Step 2, 3, or 4 below, as appropriate.

2. Step 2: Remaining parental income is earned income only:

i. From the remaining parental earned income, subtract $85.00 ($20.00 general income exclusion plus $65.00 work expense exclusion).

ii. Next, subtract the appropriate parental living allowance for the parent (and spouse of a parent) living in the household. This parental allowance is found in Table A, Figure 4a.

iii. The remaining amount is the income deemed to the applicant/beneficiary child(ren). This deemed income is treated as unearned income.

iv. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

v. If the child's total countable income is less than the appropriate income eligibility

standard in Table B, the child is financially eligible for Medicaid Only.

3. Step 3: Remaining parental income is unearned only:

i. From the remaining parental unearned income, subtract $20.00 (general income exclusion).

ii. Next, subtract the appropriate parent living allowance for the parent (and spouse of a parent) living in the household. This parental allowance is found in Table A, Figure 4b.

iii. The remaining amount is the income deemed to the applicant/beneficiary child(ren). This deemed income is treated as unearned income.

iv. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

v. If the child's total income is less than the appropriate income eligibility standard in Table B, the child is financially eligible for Medicaid Only.

4. Step 4: Remaining parental income is both earned and unearned:

i. First, subtract the $20.00 general income exclusion from the remaining parental unearned income. Then, subtract any unused portion of the general income exclusion from the remaining parental earned income.

ii. From the remaining earned income, subtract $65.00 (work expense allowance) and one-half of the remainder of earned income. Combine any remaining earned income with the remaining unearned income.

iii. Subtract the appropriate parental living allowance for the parent (and spouse of parent) living in the household. This parental allowance is found in Table A, Figure 4c.

iv. The remaining amount is the income deemed to the applicant/beneficiary child(ren). This deemed income is treated as unearned income.

v. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

vi. If the child's total income is less than the appropriate income eligibility standard in Table B, the child is financially eligible for Medicaid Only.

(f) Treatment of income deemed to a child: Any income deemable to a child is treated as unearned income and thus subject to the $20.00 general income exclusion. If there is more than one applicant/beneficiary child in the household, the deemable income is divided equally among them. However, no income is to be deemed in excess of the amount which, when combined with the child's own countable income, creates ineligibility. That portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement, is available for deeming equally to other applicant/beneficiary children in the household in addition to their equal shares of the total parental deemable income. The following steps shall apply in treatment of income deemed to a child:

1. Step 1: Combine any income deemed to the eligible child together with any countable income of the eligible child.

2. Step 2: Subtract the $20.00 general income exclusion from the child's unearned income.

3. Step 3: If the child's total remaining income is less than the appropriate income eligibility standard in Table B the child is financially eligible for Medicaid Only. The child has no

excess deemed income available for other applicant/beneficiary children.

4. Step 4: If, in the process of deeming of income to an applicant/beneficiary child, such child becomes financially ineligible for Medicaid Only, that portion of deemed income that exceeds the appropriate income eligibility standard in Table B shall be divided equally among other applicant/beneficiary children in the household, in addition to their equal shares of the total parental deemable income, and shall be counted in determining financial eligibility for Medicaid Only for such other children.

(g) A table for deeming computation amounts follows:

TABLE A

Deeming Computation Amounts

1. Living allowance for each ineligible child $257.00

2. Remaining income amount	Head of Household	Receiving support and Maintenance
	$256.00	$171.33

3. Spouse to Spouse Deeming--Eligibility Levels

a.	Residential Health Care Facility	$1,305.36
b.	Eligible Individual Living Alone with Ineligible Spouse	$1,051.36
c.	Living Alone or with Others	$ 800.25
d.	Living in the Household of Another	$ 605.76

4. Parental Allowance--Deeming to Children Remaining Income is:

		One Parent	Parent & Spouse of Parent
a.	Earned only	$1,024.00	$1,538.00
b.	Unearned only	$ 512.00	$ 769.00
c.	Both earned and unearned	$ 512.00	$ 769.00

10:71-5.6 Income eligibility standards

(a) Table B which follows shall be used to determine income eligibility for aged, blind, and disabled persons who make application for Medicaid Only benefits. The standard used for applicants/beneficiaries shall be determined in accordance with the following living arrangement categories. (For cases involving the deeming of income, this section shall be used in conjunction with N.J.A.C. 10:71-5.5).

(b) The income standard for Residential Health Care Facilities (RHCFs) (Table B, Figure I) shall be used for individuals/couples residing in such facilities which are licensed by the

New Jersey Department of Health and Senior Services. Individuals in unlicensed facilities shall always be categorized as "living alone" (N.J.A.C. 10:71-5.6(c) and Table B, II).

(c) Non-institutional living arrangements:

1. The category "living alone" (Table B, Figure II) shall be used for individuals/couples who are:

i. Living physically alone;

ii. Living in a commercial establishment, such as a motel, hotel, rooming or boarding house (including type A, B, and C, formerly known as unlicensed boarding homes) that holds itself open to the public as such;

iii. Living in a business-like arrangement;

iv. Purchasing or preparing food separately, which applies to persons living with others in a private dwelling, but separately purchasing or preparing their own food. The determination is based on the person's customary food purchase and preparation habits. Occasional joint purchase or preparation of food does not preclude a person from this classification.

v. Taking of all meals elsewhere, which applies to persons living with others in a private dwelling but taking all meals elsewhere.

vi. Persons living as members of a household but having ownership or rental responsibility and paying more than their pro rata share of the household expenses (because other members are paying less) are considered to be living alone.

(1) It is assumed that a couple share rental or ownership responsibility. Therefore, the following steps are necessary to determine if the eligible individual with ineligible spouse and other household members is paying more than his or her pro rata share of household expenses.

(A) If the eligible individual's contributions (singly) are more than his/her pro rata share of household expenses, he/she will be considered living alone. If not, proceed to (c)1vi(1)(B) below.

(B) If the contributions of both the eligible individual and ineligible spouse to the household are more than their pro rata share, they shall be considered to be living alone. If their contribution is equal to or less than their pro rata share, the applicants/beneficiaries shall be considered to be living with others (see N.J.A.C. 10:71-5.6(c)3).

(C) Household expenses are limited to: food; mortgage or rental payments; real property taxes; heating fuel; gas; electricity; water; sewer; garbage removal.

2. The category "living alone with ineligible spouse" (Table B, Figure III) applies when an individual lives with his or her ineligible spouse and there are no other persons who are part of the household. If any other persons, even minor children, are present in the same household, this category does not apply. Parents with minor children are always considered to be in the same household; therefore, the presence of minor children would result in the living arrangements described in either N.J.A.C. 10:71-5.6(c)3 or 5.6(c)4.

3. The category "living with others" (see Table B, Figure II) applies when the individual/couple resides with others and either:

i. Has ownership or rental liability and pays an amount equal to or less than pro rata share of household expenses (see N.J.A.C. 10:71-5.6(c) 1vi(1)(C)); or

ii. Does not have ownership or rental liability and is sharing household expenses with

other members of the household. Sharing is defined as paying a pro rata share or more of household expenses (see N.J.A.C. 10:71-5.6(c) 1vi(1)(C)).

4. If the individual/couple lives in a household with adults other than a spouse and the living arrangement has not already been determined in N.J.A.C. 10:71-5.6(c)1 through 5.6(c)3 above, the individual/couple may be considered to be living in the household of another (Table B, Figure IV). The specific criteria for categorization in this living arrangement is the receipt of both support and maintenance. That is, the individual/couple does not purchase either food or shelter separately in accordance with (c)4i below.

i. If meals are consumed by an individual/couple in the household and the individual/couple does not purchase either food or shelter separately, the individual/couple shall be considered living in the household of another.

(1) Separate purchase of food means that the individual/couple pays a pro rata share of the household's food or actually purchases food separately. An individual/couple receiving food stamps as a separate food stamp household shall be considered to be purchasing food separately.

(2) Separate purchase of shelter exists when the individual/couple contributes an amount equal to the pro rata share of the household's shelter expenses. Shelter expenses are limited to all items except "food" in N.J.A.C. 10:71-5.6(c)1vi(1)(C).

ii. Persons determined to be living in the household of another shall not be considered to be receiving support and maintenance in-kind pursuant to N.J.A.C. 10:71-5.4(a)12 because such in-kind income has already been taken into account in the eligibility standards.

5. Table B follows:

TABLE B

Variations in Living Arrangements	Medicaid Eligibility Income Standards	
	Individual	Couple
I. Residential Health Care Facility	$ 662.05	$1,305.36
II. Living Alone or with Others	$ 543.25	$ 794.36
III. Living Alone with Ineligible Spouse	$ 794.36	
IV. Living in Household of Another	$ 385.65	$ 605.76
V. Title XIX Approved Facility: Includes persons in acute general hospitals, nursing facilities, intermediate care facilities/mental retardation (ICFMR) and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over) or a combination of such facilities for a full calendar month.	$1,536.00+	

_____

+ Gross income (that is, income prior to any income exclusions) is applied to

this Medicaid "Cap."

(d) For the purpose of the Medicaid program, Title XIX approved facilities shall include acute care general hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and licensed special hospitals (Class A, B, and C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over).

1. Persons are considered institutionalized if they enter a Title XIX approved facility and a physician has certified that the duration of stay in the Title XIX facility (or a combination of such facilities) is expected to be 30 consecutive days or more. Income eligibility shall be determined in accordance with the variations contained in N.J.A.C. 10:71-5.4(b). However, the income of the institutionalized individual shall not be reduced by any of the income exclusions found in N.J.A.C. 10:71-5.3.

2. Institutionalized individuals, identified in (d)1 above, who are found Program eligible will receive benefits as of the date of admission.

3. Persons in a facility which is not Title XIX approved or whose stay is expected to be a period of less than 30 consecutive days will have eligibility determined in accordance with the community living arrangement which existed prior to entering the facility.

4. Temporary absence from the institution: Any temporary absence, during which the individual remains a patient of the institution, does not interrupt a continuous stay in the institution.

5. Persons living in the community who do not otherwise qualify for Medicaid benefits and who elect to participate in the hospice program, or who are assigned a slot in the CCPED or other waiver programs, will have financial eligibility determined in the same manner as those who reside in an institution.

i. Such individuals who are found eligible will receive benefits on the date of the election of hospice benefits, or the date of assignment to a waiver slot, whichever is applicable.

(e) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or part by the Division shall be included in the computation of income for financial eligibility purposes.

10:71-5.7 Post-eligibility treatment of income; institutionalized individuals

(a) The amounts specified in (b) through (h) of this section shall be deducted from the income of an institutionalized individual prior to the application of his or her income to the cost of the long term care. These deductions apply only after the individual is determined eligible for Medicaid and shall not be deducted in the determination of income eligibility.

1. Should the total deductions authorized under this section exceed the institutionalized individual's income, no assistance is available from the Medicaid program to make up the deficit. In such circumstances, available funds shall first be used to provide the institutionalized individual with his or her personal needs allowance. Any remaining deductible income may be distributed to the community spouse or other family members as decided by the institutionalized individual, not to exceed the amount authorized under this section for any individual.

2. The deductions authorized in (c) through (e) below for the maintenance of the community spouse and other family members apply only so long as there is a community

spouse as defined in (c) below. Deductions for the community spouse and other family members shall cease in the first full-calendar month after the community spouse dies, becomes divorced, or is institutionalized.

(b) A personal needs allowance in the amount of $35.00 shall be deducted from the institutionalized individual's income. In addition, gross income derived from employment that is considered essential toward satisfying the individual's developmental need to achieve a certain amount of independence shall be deducted from the individual's income. The combination of these deductions shall not exceed the amount in Table B for an individual living alone as found at N.J.A.C. 10:71-5.6(c)5.

(c) There shall be deducted from the institutionalized individual's income an amount for the maintenance of the community spouse. Except as specifically provided below, the deduction for the maintenance of the community spouse shall not exceed $1,383. For purposes of this section, a community spouse shall be defined as an individual who is legally married to an institutionalized individual under the provisions of State law and who is not himself or herself institutionalized. In arriving at the amount that may be deducted for the maintenance of the community spouse, the deductions authorized by this section shall be reduced by the gross income of the community spouse. The community spouse deduction is authorized only to the extent that the income deducted is actually made available to (or for the benefit of) the community spouse. No amount of the community spouse's maintenance deduction may be retained by the institutionalized individual.

1. If the community spouse's average monthly shelter expenses for his or her principal place of residence exceed $414.00, the amount of that excess shall increase the maximum community spouse maintenance deduction. Shelter expenses are limited to rent or mortgage (including principal and interest), taxes and insurance, a utility standard for the individual's utility expenses, and in the case of a condominium or cooperative, the monthly required maintenance charge.

2. A utility allowance shall not be authorized unless the community spouse directly incurs charges for utilities. A community spouse who directly incurs charges for heating fuel (in accordance with food stamp regulations at N.J.A.C. 10:87-5.10(a)5iv) separate and apart from their rent or mortgage payments, shall be entitled to a utility allowance in the amount specified as the "Heating Utility Allowance" at N.J.A.C. 10:87-12.1. If the community spouse does not directly incur heating fuel charges but does directly incur charges for a utility other than telephone, water, sewerage, or garbage collection, a utility allowance in the amount specified as "Standard Utility Allowance" at N.J.A.C. 10:87-12.1 shall be authorized. If the only direct utility charge incurred by the community spouse separate and apart from the rent or mortgage is the telephone the amount specified at N.J.A.C. 10:87-12.1 as "Uniform Telephone Allowance" shall be added to the community spouse's monthly shelter costs. The telephone allowance shall not be used if either of the above utility allowances have been used because those standard allowances include telephone charges.

(d) When the institutionalized individual's income is insufficient to provide the maximum authorized deduction for the community spouse, either the institutionalized spouse or the community spouse can request a fair hearing in accordance with N.J.A.C. 10:71-8.4. If

either member can establish at the fair hearing that the income generated from the community spouse's share of the couple's resources is inadequate to raise the community spouse's income (together with the community spouse maintenance deduction) to the maximum authorized level, additional resources (beyond the community spouse's share as established at N.J.A.C. 10:71-4.8) may be set aside for the community spouse. The amount of resources to be set aside shall be that amount that is determined sufficient to generate sufficient income to raise the community spouse's gross income to the maximum authorized level.

(e) If either the institutionalized spouse or the community spouse is dissatisfied with the determination of the amount of the community spouse maintenance deduction, he or she may request a fair hearing in accordance with N.J.A.C. 10:71-8.4. If it is established at the fair hearing that the community spouse needs income above the amount established by the community spouse maintenance deduction due to exceptional circumstances resulting in financial duress, there shall be substituted for the community spouse maintenance deduction such amount as is necessary to alleviate the financial duress and for so long as directed in the final hearing decision.

(f) If a court has entered an order against an institutionalized spouse for monthly income for the support of a community spouse and the amount of the order is greater than the amount of the community spouse deduction, the amount so ordered shall be used in place of the community spouse deduction.

(g) A family member maintenance deduction shall be calculated for each family member of the institutionalized individual.

1. For purposes of this section, family members must reside with the community spouse and shall be limited to the following persons:

i. Children of either member of the couple who are under the age of 21;

ii. Children over the age of 21 who are claimed as dependents by either member of a couple for tax purposes under the Internal Revenue Code;

iii. Parents of either member of a couple who are claimed as dependents for tax purposes under the Internal Revenue Code as dependents by either spouse; or

iv. A brother or sister (including half-brothers and half-sisters and siblings gained through adoption) of either member of a couple and who are claimed as dependents for tax purposes under the Internal Revenue Code.

2. The family member deduction shall be computed as follows. The family member's gross income shall be subtracted from $1,383. One-third of the remaining amount shall be the family member deduction for that family member.

(h) If a physician has certified that the individual will be institutionalized for a temporary period only and is likely to return to the residence within six months of the date of institutionalization, a maximum of $150.00 may be deducted from the institutionalized individual's income for the maintenance of his or her home in the community. This deduction shall be limited to the actual costs of such maintenance (for example, mortgage or rent payments, taxes, insurance, and other incidental costs) or $150.00, whichever is

less. This deduction may be applied against the individual's income for no longer than six months. This deduction may not be applied if a deduction has been made for the maintenance of a community spouse or other family member residing in that residence.

1. This deduction must be applied to the costs of maintaining the residence and may not be accumulated by the institutionalized individual.

(i) If the institutionalized individual has health insurance covering himself or herself, the amount of the insurance premiums shall be deducted.

1. If the premium is billed other than monthly, the amount of the premium shall be prorated and deducted accordingly.

2. If the premium covers other individuals in addition to the institutionalized individual, only that portion of the premium attributable to the institutionalized individual shall be deducted.

(j) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

10:71-5.8 Eligibility under life care and pay-as-you-go agreements

(a) In a contractual agreement where the individual has transferred his available assets to the facility in exchange for full medical care in the institution, the institution has a legal responsibility to provide such care and Medicaid benefits are not payable for the institutional care. However, Medicaid eligibility may exist in the following circumstances (see also N.J.A.C. 10:71-5.4(a)13):

1. When it can be determined that no enforceable contract exists (for example, because the facility is financially unable to fulfill its responsibilities under the contract and all terms of the agreement are thus void), the facility has a legal obligation to refund to the individual any assets which remain from the amount assigned at the time the contract was signed. The individual may be eligible for Medicaid Only as long as all other eligibility criteria (including resources) are met.

2. When a contract is not actually rescinded and the individual retains his or her right under the terms of the contract but, where his or her contract rights for care in the facility are not fully met, Medicaid benefits may be available for those medical expenses not being met by this facility if the individual meets eligibility requirements.

3. When the contractual agreement for care in the facility does not include all of the medical care (for example, is limited to basic room and board), Medicaid benefits may be available for those medical expenses not covered by the contract as long as all eligibility criteria are met.

4. In those contractual situations above in which Medicaid eligibility may exist, the value of in-kind room and board is not considered income.

10:71-5.9 Deeming from sponsor to alien

(a) For the purposes of determining eligibility for Medicaid Only for a legal alien (applying for the first time on or after October 1, 1980), the income and resources (see N.J.A.C. 10:71-4.7) of any person who sponsored the alien's entry into the United States will be

deemed to the alien. Such deeming applies for a period of three years from the month of the alien's entry into the United States. However, deeming shall not apply to any alien who is:

1. Admitted to the United States under the provisions of section 203(a)(7) of the Immigration and Nationality Act which were in effect prior to April 1, 1980;
2. Admitted to the United States under the provisions of section 207(c)(1) of such Act which became effective March 31, 1980;
3. Paroled into the United States as a refugee under section 212(d)(5) of such Act;
4. Granted political asylum by the Attorney General;
5. Determined to be blind or disabled if such blindness or disability began after the date of admission into the United States for permanent residence; or
6. Sponsored by an institutional sponsor such as an employer or a church.

(b) In the event an alien is sponsored by a person subject to the deeming rules at N.J.A.C. 10:71-5.5, those rules will be used in lieu of the sponsor-to-alien rules.

(c) No inquiry shall be made regarding a sponsor's financial circumstance unless the alien's own countable income and resources indicate potential program eligibility.

(d) Normal income exclusions do not apply in deeming of a sponsor's income to an alien. Additionally, SSI benefits, TANF payments, as well as any other public income maintenance payments are not excluded in sponsor-to-alien deeming.

(e) To determine the amount of income to be deemed to an alien, the CBOSS shall proceed as follows:

1. Determine the total gross earned (wages and net earnings from self employment) and gross unearned income of the sponsor (and spouse if living with the sponsor).
2. Subtract $512.00 for the sponsor, $768.00 for the sponsor if living with his or her spouse, $1,024 for the sponsor if his or her spouse is a co- sponsor.
3. Subtract $256.00 for any other dependent of the sponsor who is or could be claimed for Federal Income Tax purposes.
4. The remaining amount is deemed as unearned income to the alien.

(f) In the event that a sponsor has sponsored more than one alien, there is no proration of deemable income among the sponsored aliens. The income is fully charged to each alien for which the sponsor has executed an affidavit of support.

End OF SUBCHAPTER 5

SUBCHAPTER 6. CASE RECORDS AND FILES

10:71-6.1 Purpose of case records

The case record is a complete record in support of the CBOSS's decisions and actions for each case.

10:71-6.2 Contents of the case record

(a) The following items shall be included in the case record:

1. The narrative recording;
2. All medical reports and record of action from the MRT (appropriate cases);
3. All forms related to financial eligibility; and
4. All related correspondence, memoranda and documents except those which are required by law and regulation to be maintained in some other files.

10:71-6.3 Forms applicable to the Medicaid Only program

Forms applicable to the Medicaid Only program (aged, blind and disabled) are listed on page 1 of Appendix A; sample forms follow that list.

10:71-6.4 Maintenance and custody of case records

All case record material relevant to each family shall be maintained under an appropriate registration number. All records shall be appropriately indexed and filed.

10:71-6.5 Movement of case records

(a) No case record or official part of such record shall be removed from its designated filing cabinet without an identifying record of the person who has custody of it.

(b) No case record or official part shall be removed from the offices of the county welfare board except at the specific authorization of the director, deputy director or duly designated representative of the director.

10:71-6.6 Retention and destruction of records

For policy and procedure on retention and destruction of case records see N.J.A.C. 10:69.

END OF SUBCHAPTER 6

SUBCHAPTER 7. OTHER PAYMENTS

10:71-7.1 General provisions

Medicaid Only beneficiaries, like Supplemental Security Income (SSI) beneficiaries, are eligible to receive services and related service payments for services identified at N.J.A.C. 10:71-7.2 and for payment of burial and funeral expenses as authorized by N.J.A.C. 10:71-7.5. Such payments as deemed necessary and appropriate by the county board of social services shall be paid either directly to the vendor of the service or by a check issued to the eligible person.

10:71-7.2 Services and service payments

Eligible applicants and beneficiaries as defined under the State Plan for Title XX of the Social Security Act may receive the services and related service payments specified in the State Plan. The Division of Youth and Family Services is responsible for providing the county board of social services with policies and procedures regarding these service programs, including those specified in N.J.A.C. 10:71-7.3.

10:71-7.3 Other service payments

Eligible applicants and beneficiaries of Medicaid Only are also eligible to receive certain service payments as authorized at N.J.A.C. 10:69-10.22(b) and 10.23. These include payments for expenses incident to homemaker service, travel costs for health care, and childcare in certain situations.

10:71-7.4 Emergency assistance payments

Eligible applicants and beneficiaries of Medicaid Only are not eligible to receive emergency assistance as defined in N.J.A.C. 10:69-10.23.

10:71-7.5 Payment of burial and funeral expenses

The county board of social services is directed, under certain situations, to provide payments for burial and funeral expenses on behalf of Supplemental Security Income and adult "Medicaid Only" beneficiaries, as well as former Old Age Assistance, Disability Assistance and Assistance for the Blind beneficiaries. The procedure authorizing these payments is located at N.J.A.C. 10:90-8.

END OF SUBCHAPTER 7

SUBCHAPTER 8. RESPONSIBILITIES

10:71-8.1 Other agency responsibilities

(a) Determination of continuing eligibility: The eligibility of each case shall be redetermined at least once every 12 months. This redetermination provides an opportunity to evaluate the total situation and enables the eligibility worker to ascertain whether the individual's eligibility has changed.

1. It shall be the agency's responsibility to review indications of ineligibility as they occur and to discontinue Medicaid Only eligibility when appropriate and without delay. The agency shall notify each applicant/beneficiary of any agency decision that relates to his or her eligibility status in accordance with the provisions of (d) below and 8.3.
2. The individual, or his or her authorized representative, shall execute a formal written application, Form PA-1G, Application and Affidavit for Medical Assistance Only (Aged, Blind, or Disabled), for continuance of assistance at least once every 12 months.

(b) Process of redetermination:

1. Redeterminations of eligibility require the completion of Form PA-1G-NJR2 (Redetermination Form). The CBOSS may require that the form be completed during a face-to-face interview. However, at the option of the CBOSS, and with the approval of the beneficiary, the face-to-face interview may be eliminated. Form PA-1G-NJR2 (Redetermination Form) may be mailed to and completed by the beneficiary and mailed to the CBOSS. All factors of eligibility subject to change (with the exception of disability and blindness factors) must be verified or reverified.

i. When a loss of assistance will result, the face-to-face interview shall be required, unless the agency documents a clear refusal by the beneficiary to have a face-to-face meeting. Before benefits are terminated, a beneficiary shall be offered a face-to-face home visit. The visit shall not be required to be in the office, but at the beneficiary's request, in the home.

2. Redetermination of financial and resource eligibility: The eligibility worker shall review all eligibility factors in accordance with the provisions set forth in N.J.A.C. **10:71-**3, 4, and 5. Particular attention shall be directed to identification of any changes in resources and income.
3. Completion of the Medicaid Eligibility Worksheet: It is the responsibility of the eligibility worker to complete a new Form PA-1E when eligibility is to be continued, or terminated. A PR-1 Statement of Income Available for Long Term Care Facility Payment should be prepared for persons in institutions only when there is a change with regard to the amount of income available for medical reimbursement.
4. Need for institutional care: Official review of this factor on a routine basis is not required, but when medical or social evidence indicates that specific determination should be made, the CBOSS shall institute such an investigation.

(c) Recording and recommendation: A Summary Report, Form PA-2D, concerning all pertinent information shall be completed for each contact with the individual, whenever it occurs. Whenever a change in circumstances affects any facet of eligibility, a Medicaid Eligibility Worksheet (Form PA-1E) shall be prepared. The summary shall clearly state the

basis for any termination of eligibility. Following each redetermination of eligibility, it is the responsibility of the eligibility worker to recommend that eligibility be continued or terminated.

(d) Notice of agency decision: Each applicant/beneficiary shall receive written notice of any agency decision which relates to his or her eligibility status at least 10 days prior to any change in his or her eligibility status.

10:71-8.2 Redetermination of medical eligibility

(a) Redetermination of disability and blindness factors shall be done for every Medicaid Only beneficiary at intervals set by the Division of Medical Assistance and Health Services, Medical Review Team (MRT), except those beneficiaries who are currently receiving SSA Disability Insurance Benefits. The redetermination review date is designated on Form PA-8, Record of Action: Medical Eligibility Factor (see N.J.A.C. 10:71-3.13(g)).

(b) An individual who has been determined to be disabled or statutorily blind shall, if requested with reasonable notice, present himself or herself for and submit to examinations or tests, and shall submit medical and other evidence necessary for the purpose of determining whether he or she continues to be disabled or statutorily blind.

(c) In Medicaid Only cases, the CBOSS shall take into account the redetermination review date on Form PA-8 in scheduling both the annual review and interim visits. The CBOSS may adjust the date for case submittal to the Medical Review Team (MRT), to coincide as closely as is practical with either the annual review or with an interim visit, but such adjustment shall assure that the case will be submitted not more than two months earlier and in no event later than the date originally set on Form PA-8.

(d) The Medical Review Team (MRT) will maintain a control file in order to ensure appropriate and timely reevaluation by the medical review team (MRT). The Medical Review Team (MRT) will notify county board of social services one month in advance of cases scheduled for such review by means of Form PA-655, Cases for Medical Review Team Reevaluation Due During the Month.

(e) The eligibility worker shall organize his or her caseload controls (notebooks, index, and other related materials or equipment) so that he or she will be alerted sufficiently in advance of redetermination review dates to enable him or her to obtain any specific medical information or reports requested on the last Form PA-8. The data and reports so submitted must be "current."

(f) When a case is to be submitted to the Medical Review Team (MRT) for redetermination review, the eligibility worker shall prepare Form PA-6A, Interim Medical Social Report in detail. Form PA-6A shall be placed on top of all forms, reports and related data previously submitted.

(g) Medicaid coverage shall be continued, if financial and resource eligibility continues to

exist, unless and until the CBOSS is advised by the Medical Review Team (MRT) that the individual no longer meets the disability and blindness requirements or the individual withdraws voluntarily.

(h) Upon receipt of records from the Medical Review Team (MRT), the CBOSS shall follow the procedures as outlined in N.J.A.C. 10:71-3.13(g).

10:71-8.3 Notice of county board of social services decision

The county board of social services shall promptly notify, in writing, the applicant for, or beneficiary of, Medicaid Only of any agency decision. The policies and procedures outlined in N.J.A.C. 10:87-7.1 through 7.6 shall be followed.

10:71-8.4 Complaints and fair hearings

(a) It is the right of every applicant for, or beneficiary of, Medicaid Only to be afforded the opportunity for a fair hearing in the manner established by the policies and procedures set forth in N.J.A.C. 10:49-10 and 10:69-6, regarding complaints and fair hearings (see N.J.A.C. 1:1). Complaints and fair hearings regarding Medicaid Only eligibility should be referred to:

Division of Medical Assistance and Health Services
Office of Legal and Regulatory Liaison
PO Box 712
Mail Code #3
Trenton, New Jersey 08625-0712

(b) In situations where an applicant or recipient is denied medical services to which he or she feels that he or she is entitled, a request for a hearing and a brief explanation of the situation should likewise be sent to the Office of Legal and Regulatory Liaison.

10:71-8.5 Fraudulent receipt of assistance

To protect the assistance agency and the public against the commission of fraud, the policies and procedures as defined in N.J.A.C. 10:81-7.40 through 7.45 (fraudulent receipt of assistance) shall apply to the Medicaid Only program.

10:71-8.6 Reporting criminal offenses to law enforcement authorities

Investigation of new applications or investigations for redetermination or eligibility may on occasion present indications to the CBOSS that a crime may have been committed. In such a situation, the procedures outlined in N.J.A.C. 10:69-9.19 through 9.20 (reporting criminal offenses to law enforcement authorities) are to be followed.

10:71-8.7 Safeguarding information

The Federal Social Security Act requires that a state must provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of public assistance. Therefore, the policies and procedures outlined in N.J.A.C. 10:69-9.8 through 9.10 (safeguarding information) apply to the Medicaid Only program.

10:71-8.8 Nondiscrimination in public assistance programs

Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352) and Section 504 of the Federal Rehabilitation Act of 1973 prohibit discrimination on the ground of race, color, national origin, or handicap in the administration of a program for which Federal funds are received. Therefore, the policies and procedures relating to those acts, as outlined in N.J.A.C. 10:81-7.36 through 7.38 (nondiscrimination in public assistance programs) are to be strictly observed.

END OF SUBCHAPTER 8

SUBCHAPTER 9. MEDICAL ASSISTANCE FOR THE AGED CONTINUATION

10:71-9.1 General statement

The Medical Assistance for the Aged Continuation (MAAC) provides payment for the costs of medical services for certain former beneficiaries of the program of Medical Assistance for the Aged (MAA). Eligibility is based on continued medical need and lack of eligibility for any other program through which the cost of medical care is provided. Beneficiaries receive the full spectrum of Medicaid services.

10:71-9.2 Initial certification

(a) Certification begins for those persons and only for those persons who were in certified status in the MAA program at the close of business on June 30, 1982 and those persons that filed MAA applications on or before June 30, 1982 and whose eligibility was established in accordance with regulations and case circumstances in effect on that date. The initial certification period in MAAC consists of the remainder of the current MAA certification period (see N.J.A.C. 10:71-9.4(a)).

(b) Recertification: Eligible persons will be recertified by the CBOSS for such additional periods, usually for three months or as specified by DMAHS/MRT (see N.J.A.C. 10:71-9.4).

(c) Extension of certification periods: The CBOSS will extend initial or subsequent certification periods in units of one month as may be necessary, pending receipt of a medical need determination from DMAHS/MRT and/or, if applicable, to comply with requirements for timely notice of adverse action (see N.J.A.C. 10:71-8.3). Extensions shall not be made for any other reasons.

10:71-9.3 Termination

Once terminated for any reason, including loss of medical certifications, a case shall not be reopened under the provisions of this subchapter.

10:71-9.4 Continuation of medical need

(a) Submittal of data to DMAHS/MRT: Thirty days prior to the end of each certification period, the CBOSS will forward to DMAHS/MRT photocopies of all forms and reports bearing on the individual's need for continued inpatient hospital services, skilled nursing home services, or home health care services required by reason of an illness necessitating confinement at home for a prolonged period.

(b) Response by DMAHS/MRT: The DMAHS/MRT will review the submitted material and notify the CBOSS of its determination. The determination will specify whether continuation does or does not exist.

(c) CBOSS Action: Upon receipt of the DMAHS/MRT determination the CBOSS will, as appropriate, move to terminate or recertify the case for such periods as may be required to make the review month become the final month of the new certification period.

10:71-9.5 Eligibility for other programs

(a) Review: The CBOSS will review each MAAC case in accordance with (a)1 below for potential eligibility for other assistance programs through which the costs of medical care may be met. Those programs will not include General Assistance but will include such programs as SSI and Medicaid Only.

1. Review times: The CBOSS will conduct a review with respect to other program eligibility at time of initial certification, at the beginning of the review month, whenever any change in client income occurs and at the time of any change in standards of other appropriate programs.

(b) Referral: If eligibility is found for regular Medicaid Only, the CBOSS will convert the case accordingly. If potential eligibility is found for a program administered by another agency, the CBOSS will make referral promptly and will institute procedures for follow-up of the referral. Upon acceptance of the individual into any other program through which medical costs are met, the CBOSS will terminate the MAAC case.

END OF SUBCHAPTER 9